

HARVARD MEDICAL

ALUMNI BULLETIN

WINTER 1986-87



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INSIDE H.M.A.B.

It has often been said that doctors make poor patients. Although well-qualified to treat illness, they are ill-equipped to be sick.

In this issue, Howard Spiro '47 suggests that doctors are poor patients because to "play the role of omnipotent healer, the physician must seem immune to disease"—and that doctors learn "to measure, not conjecture—to act, not reflect." James Groves '72 finds that doctors develop a myth system with a fatal flaw—"the belief that it can't happen to us, a defensive denial of our own vulnerability to that ultimate antagonist, death."

Six years ago, George Vaillant '59 observed in the *Bulletin* that doctors "like taking care of other people because we are dependent, yet we tend to keep our dependency needs secret from ourselves."

Whatever the reasons, for most physicians the most thorough knowledge of the profession offers few clues about how to cope with their own experiences of illness.

We include in this issue several accounts of patienthood from physicians. Joseph Murray '43B reflects on three episodes of serious illness that have defied exact diagnosis. Judith Alexander Brice '71 describes a medical odyssey in which she found compassion rarer than second (and third and fourth) opinions. Robert Lawrence '64 contributes a piece on having an anencephalic baby—a case study he first wrote for use in the New Pathway curriculum.

James Kreisle '42 and Benson Roe '43A describe learning to age and to live with, respectively, chronic heart disease and progressive motor neuropathy.

On the lighter side, Peter Rintels '83 explores the metamorphosis of Ironman of the Wards, a character who emerges in almost all newly-minted doctors—even those who as medical students imagined themselves dying of every disease detailed in *Harrison's*.

Finally, *Bulletin* editor Gordon Scannell supplies a portrait of Francis Weld Peabody in the form of reminiscences from those who knew him in his last days. Known foremost as the author of *The Care of the Patient*, Peabody learned firsthand the secret of caring for the patient.

We end with our second in a series of reports on the status of minorities at Harvard Medical School. In the first, Clyde Evans, director of the Office for Academic Careers, wrote about minority representation on the faculty (spring 1986). In this issue, Alvin Poussaint and Brenda Lee-Walker report on the school's efforts to attract and retain minority students.

—Lisa Drew

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ALUMNI BULLETIN

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ALUMNI COUNCIL: PRESIDENT'S REPORT

Musings on the Functions of an Alumni Association

by James A. Pittman Jr.

What is the function of our alumni association? Why do we have one? Our constitution says, "The objective of this Association shall be to present the opinions and recommendations of the alumni to the administration and faculty of the Harvard Medical School, to increase the effectiveness of the Harvard Medical School in advancing medical education and improving the care of the sick. The Association shall promote acquaintance and good fellowship among the alumni for their mutual benefit and for the good of the School and of their community."

The first sentence was added in the amendments of June 1985. It would be interesting to see whether this approach—emphasizing a role of the association in advising and perhaps criticizing the administration and faculty of the school—is prevalent among alumni associations. It is not explicitly an objective for Harvard Law School or Harvard College alumni, and probably not for many other alumni groups. Most members of such associations are probably busily embroiled in the day-to-day activities, crises, and objectives of their individual lives and give little thought to their alumni associations, particularly since most physicians are members of at least two or three (high school, college, and medical school).

It is said that there are three human constituencies of schools: the students, the faculty and administration, and the alumni. The functions of the first two are fairly clear. The students learn, obtain training experiences under supervision, and ultimately gain official approval with a certificate or diploma. The faculty help the students in these endeavors (and do research and service along the way; but that's another argument). The role or objective of alumni is more ambiguous.

Perhaps it is because I see the

situation from the perspective of a medical school dean as well as an alumnus, but I wonder whether perhaps we have overemphasized the role of critic and even adversary. During discussions of this issue last year, one heard such phrases bandied about as, "our association is the conscience of the medical school." It sounded great and noble and in the spirit of the open-minded New England town

On cooler reflection, I wonder if the phrase "our association is the conscience of the medical school" is not pregnant with mischief.

meeting, so it swept us along to unanimous approval. However, on cooler reflection, I wonder if perhaps that phrase is not pregnant with potential for mischief.

I can tell you as a dean that there are so many "consciences" around these days it's nearly impossible to get your regular work done. (That work consists mainly of getting the best possible people together, both students and faculty, then keeping them happily and productively engaged in medicine, all in the most modern and up-to-date facilities possible, certainly ahead of everybody else.) The "consciences" are all reasonable, plausible, and quite justifiable. There are the institutional review boards for humans, and the compa-

rable boards for animals to be used in experiments or teaching. There are the accrediting agencies—at least three important for medical schools (Liaison Committee on Medical Education, Accreditation Council on Graduate Medical Education, and Joint Commission on Accreditation of Hospitals). There are the government auditors for NIH and the separate auditors for Medicare and Medicaid. There is the federal OMB Circular A-21 on how to spend your time and money.

Then there are the internal committees on fraud in research, faculty senates or similar bodies, and self-generated ad hoc faculty groups. HMS has over 2,000 voting faculty, and they fight quite vigorously—openly and informally—for what they think is right. There are the town doctors complaining about unfair competition and excessive class size. And there are applicants worrying about the morality of downsizing the classes—at least till they get in—and threatening to go to the Caribbean. The town-gown issue is especially inflammatory these days, and threatens to get worse nationwide.

Alumni do offer the possibility of broader, and perhaps medically more practical, perspectives. But I think it is unlikely we shall frequently uncover problems not already suspected by the faculty and administration and being dealt with by them. It is quite possible that we will be seen as bringing a great lack of understanding to such problems.

Of course, that notion should not deter us from presenting our views as alumni, and we shall. The Alumni Survey Committee should be a good mechanism to do so. It has served well in the past, though it has not been used vigorously the past several years. I hope we can reactivate it, and I look forward to your sugges-

tions. You can write them care of the Alumni Office at HMS.

During the election activities in early November, it occurred to me that perhaps we should view our main overall function as *VOTIVE*. Webster says the adjective "votive" means "offered or performed in fulfillment of a vow or in gratitude or devotion." The noun "votary" means "enthusiast, devotee; a devoted admirer; a devout or zealous worshiper; a staunch believer or advocate; (archaic: a sworn adherent)." These words are in turn related to the Latin *votum*, for vow: "a solemn promise or assertion, especially one by which a person binds himself to an act, service, or condition." And the word *vote* is from the same root.

These words seem to me to carry the idea we are searching for. HMS alumni are bound by our common gratitude for what we gained at HMS and by our devotion to the school and belief in its ability to continue to establish and maintain the highest possible standards for medicine. We can *VOTE* for HMS in many ways—certainly by criticizing it, but also by praising it privately and publicly; by giving it whatever money we can and encouraging others to do the same; by lobbying for it when possible; by helping students, faculty, and administration solve the school's problems without causing more problems; by rallying together for fellowship and support of each other and the school; and perhaps most important, by just being excellent doctors! □

James A. Pittman Jr. '52 is dean, professor of medicine, and professor of physiology at University of Alabama School of Medicine in Birmingham.

LETTERS

Pride and Prejudice

Fans' Notes

I always enjoy the *Bulletin*, particularly the alumni notes. As a member of the Class of 1985, I always go straight to the back of the notes, reading with curiosity news of other HMSers from my class or those close to mine.

But in last year's winter issue I also read the news of HMSers from past years, and made a wonderful discovery in the process. What a beautiful story is told in the notes as a whole! Marriage announcements, the birth of new children, relocating to distant parts of this country and the world, careers soundly taking off with promotions to tenure, chairmanships, directorships. Then the downslope of life—retirement, the death of spouses, the development of new interests, the frailty and debility of growing old—blindness, ruptured aneurysms, fractured hips.

There is encouragement for an overworked intern in this note from Clark Young '21: "My lovely wife Mona passed away in October following a prolonged illness. She was 84. I had my 90th birthday in July. My health remains good, though I'm having a difficult time recovering my spirits. However, I'm sure she is in happier circumstances, and I will meet her again. Best regards to all '21ers, to all alumni, and to HMS."

Thank you for a wonderful capsule of life.

—Michael T. Myers Jr. '85

The experience of having an article published in the *Bulletin* was remarkably important to us at the new HMS Office for Parenting. Following the publication of the Spring 1986 issue on doctors and family, we received about 60 calls from alumni and others who asked for extra copies of the issue or for information from the office. (We actually had requests for reprints!) We were also contacted by

deans' offices at several medical centers in other states who wished to set up offices for parenting at their schools. It was a surprise to us to receive calls as well from the media, who apparently also read the *Bulletin*.

More important, though, was the extraordinary treatment I received from Lisa Drew and Lisa Derman of the *Bulletin* staff. In addition to being skillful and creative editors, they were personal, enthusiastic, and patient. Indeed, their editing improved the article to such a professional level that many commented to us on the quality of the writing.

For us, the *Bulletin* proved to be a source of superb reporting and helpful dissemination of HMS news. We would like to thank the staff for their help.

—Maureen Sayres, M.D.
Director, Office for Parenting

Although I am not a regular reader of the *Bulletin*, I consider myself quite fortunate to have stumbled upon the Spring 1986 issue. I read it from cover to cover and enjoyed every article. I particularly enjoyed John Mack's interview with medical students whose parents are doctors, which I found to be warm, humorous, and enlightening. I also appreciated the candid responses of his interviewees. I saw physicians in a whole new light! Thanks for publishing it.

—Cheryl A. Cresta, Ed.M.
West Roxbury VA, MA

The Summer 1986 *Bulletin* on the teaching and learning of medical ethics is one of the finest I have ever read on the subject.

—Robert A. Stewart '36

The Summer 1986 *Bulletin* was both enjoyable and provocative and sets a challenging precedent. Congratulations.

—Carl Walter '32



Your publication is an especial enjoyment for those of us furthest away from Boston, and I thank you for your continued high quality and presentation of such interesting issues. Keep up the good work.

—Daniel Einhorn, M.D.
San Diego Endocrine & Medical
Clinic

More on the Dawn of Antibiotics

The spate of letters on the first uses of antibiotics that followed Joseph Placak Jr.'s article in the Winter 1985 *Bulletin* spurs me to add one more. During the winter of 1936-'37, I, along with Lewis Thomas '37 and others of our class, lived at Massachusetts General Hospital and did lab work at night for the private patients. Thus I had the opportunity to draw blood, under the watchful eye of his mother, from the Roosevelt son treated by Placak. We were duly impressed with his recovery.

After graduation I went to Children's Hospital for a couple of years. In early fall of 1938, Dr. Blackfan returned from his summer retreat to tell us of reading about a new drug in England called, I believe, M and B 397. He suggested that we use it in the treatment of pneumonia. Our lives as residents changed dramatically. The previous year I had spent many a night using testing material to type out the exact strain of pneumococcus to treat our young patients. Gone was that work (and Lederle's great investment in specific antisera)!

It was not until the summer of 1944, when I was transferred to a makeshift tent hospital in Naples, that I saw the power of penicillin. Patients that would have languished in the hospitals with either gonorrhea or syphilis were being sent back to Anzio within a couple of days of their rest and relaxation in Naples.

Quite separately, let me thank you for the excellent issue on parenting, as well as the fine obituary for my fellow parishioner at St. Luke's Bethesda, Bob Gordon '49. We truly miss him.

—Henry H. Work '37

The Sound and the Fury

The article by Clyde Evans in the spring issue of the *Bulletin* is disturbing in its implication that there is significant discrimination against blacks within the medical school. The statistics, of course, are meaningless if one does not know the number of minority applicants actually turned down and whether or not they are academically competitive with white applicants who are accepted.

The implication that W.A. Hinton was for a time denied advancement to full professorship because of his race is a specious argument. One only has to remember that Fuller Albright, one of Harvard's most prestigious investigators, never was promoted to full professor, although he [was white and] spent his entire academic career at Harvard Medical School.

The entire article carries an undercurrent of paranoia and presents not one shred of evidence that the percentage of minority medical students, house officers, research fellows, and faculty is in any way related to racial bias within the medical school. It would be of great interest if Clyde Evans could produce such data, if such were possible. The article might then be worthy of publication.

—Robert L. Nielsen '51

I would like to clarify what appears to be a misunderstanding on the part of Dr. Nielsen. It involves the different roles played by HMS and the

Harvard-affiliated hospitals.

I made no claims in my piece regarding racial discrimination at HMS; I neither affirmed nor denied it. The school itself was not my primary focus. The medical school, not the hospitals, is responsible for medical students (admittedly a slight oversimplification, as most departments are clinical, located at hospitals). The hospitals, not the medical school, make the decisions to appoint faculty and house officers. Since my office is specifically charged to assist those at the post-graduate level, and since the article was about faculty, I was silent on the practices of the medical school as an institution.

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The medical school has had an admirable record in recent years. As I pointed out in the article, the student body is about nine percent black, which is noticeably higher than the national average of about five percent. HMS has achieved this record while maintaining excellent results in graduating and matching those students. Indeed, HMS's minority program is recognized nationwide as a model for other schools. Hence, if there was any implication in the article about HMS, it was precisely the opposite of that understood by Dr. Nielsen.

I also made no claims of racial discrimination in the hospitals. I did want it to be known that while blacks constitute 5.2 percent of the available national pool of trainees, they comprise only 1.8 percent of Harvard-affiliated trainees. This is a statement of fact, not a claim of racial discrimination. At the same time, I tried to make clear that the responsibility and power to address the situation reside in the hospitals, not at the medical school. And I made the point that genuine efforts have been made within the hospitals to address the situation.

One final thought. I ask readers to beware of the pitfall of demanding absolute proof of racial discrimination. That is, to my mind, misguided "objectivity." Of course, I do not counsel accepting the charge of racial discrimination to explain every in-

stance of interpersonal unkindness or institutional misfortune. At the same time, we cannot deny that we live in a society permeated with racial (and other) biases, and, in many instances, racial discrimination—many forms of which were, until recently, enshrined in law. And who among us can deny the evidence in our own hearts? Racial bias and discrimination are simply a part of the world in which we live—an acknowledgement that does not require us to produce compelling evidence or point an accusing finger. Exclusion and underrepresentation—particularly in such a prestigious profession as medicine—are classic examples of the tragic and wasteful results of racial (and other) discrimination in our society. It remains for us all to care enough to do what we can to remedy the effects of such a legacy.

—Clyde Evans

Director, Office for Academic Careers

The article titled the "Forced Flowering of a Medical Ethic" in the Summer 1986 *Bulletin* should be nipped in the bud. The article includes the following: "After informing the parents that their baby had died, I called the obstetrician who had delivered her to let him know. He said he thought in the old days things were handled better. Taken aback, I asked how that might be. He said that he had heard that when women were delivered under scopolamine, it had not been uncommon, when an infant was born with severe deformities, to call for a pail of water and 'hold the infant under.'"

The author of the article is completely in error and poorly informed. The "scopolamine" era was in the 1930s to the 1960s in Boston. Other areas of the country used much less medication. From 1939 to 1960 I was an obstetrician at five Boston suburban hospitals delivering over 4,500 babies. I never witnessed or heard of such a practice as "holding the infant under."

I would also remind the author that an anesthetist was in attendance at all births, along with charge, float, and nursery nurses. All procedures were conducted according to accepted practice and were subject to review. I was well acquainted with most of the Boston obstetricians of that time. I'm sure that those who are still around would concur with me.

—Langdon Hooper '36

Sparr's Redux

Some time ago, the Bulletin ran an invitation for anecdotes about Sparr's Drugstore for a potential article. The anecdotes didn't materialize, and we put off the idea. One recent letter writer, however, offers the following:

Although I am not a graduate of Harvard Medical School, I do occasionally receive the *Bulletin* through my friend John Grover '56.

I practiced in Boston during the '60s with offices in Natick, Concord, and Waltham. When I first started practice, many of my junior teachers were experimenting with different ways to improve their stethoscopes for listening to bruits. At that time I purchased a \$4.00 stethoscope at



Sparr's Drugstore. I was able to tape its tubing together (see photo) and eliminate the diaphragmatic portion of the scope without changing the other characteristics. It became the best bruitscope, as far as I was concerned, that I had ever seen or heard through. I still have the scope and use it regularly in office and bedside examination to scope for bruits. So far, I have not run across a scope used by specialists, residents or otherwise, that could compare to it for listening to a bruit and determining all of its characteristics of pitch, volume, and quality.

—William S. Weir, M.D.

University of North Dakota School of Medicine

Alumnus' Query



HMS alumni/ae who were recipients of a Cheever Scholarship during their course of study are requested to contact:

Joseph F. Ross, M.D. ('36)
11246 Cashmere Street
Los Angeles, CA 90049

CAMPAIGN REPORT

A Party for HMS

"Today we begin a great venture," said Harvard Medical School dean Daniel C. Tosteson at the formal kick-off of the Campaign for the Third Century in October.

In the audience were the 250 alumni, corporate executives, and professional men and women who have volunteered to help HMS raise \$185 million over the next five years. They had come to a black tie dinner dance at Boston's Parker House to celebrate their success in raising a \$58 million nucleus fund ("We have reached base camp," noted Tosteson). And they were there to toast the future ("Celebratory occasions," remarked Harvard president Derek Bok after the dinner, "offer us a rare opportunity to take a longer view.")

Why does HMS need a capital campaign?

Explained Tosteson in an afternoon address to campaign leaders: "The continuing burden of human illness, the ignorance that bars the path towards reducing the burden, the responsibility of Harvard to participate in the effort to dispel ignorance through research and education, the great opportunities now open to medical science, the superb quality of the persons—students and faculty—who come to Harvard Medical School to learn medicine, the inadequate physical plant and financial resource base: these are the principal reasons I propose the campaign."

At the evening celebration, Bok addressed the common perception that medical schools receive plenty of support from the federal government. "In reality," Bok said, "federal support leaves critical gaps. It does not help young investigators to get started quickly enough on their research. It makes no provision for educational facilities and contributes far less than is needed for the renova-



Thomas Cabot, National Campaign Committee, and Harvard president Derek Bok



Robert Gwinn, HMS Visiting Committee; Carl Walter '32; and HMS dean Daniel Tosteson '48



'Woody' Edgar '41 with wife, Willie



Perry Culver '41 and David Potter, Neurobiology chairman



Ellen Gordon, NCC, and Oglesby Paul '42

tion and construction of laboratory facilities. It also does not provide nearly enough support in the form of financial aid for medical students."

Bok said of HMS, "I don't know any place else in the university where you can see so conclusively the effects of research and education on human welfare, no other institution in this country that has done so much or contributed so much."

Of all the campaign needs, Bok said, "the most significant is medical

education." Referring to the New Pathway, he said, "No other educational initiative in the university compares with this in scope. It is a wonderful thing that an institution as old and as successful as this one is willing to take the risk on such a bold educational venture. No investment in higher education at Harvard or at any other university can do so much."

Campaign co-chairman Colman Mockler Jr. told the volunteers, "The top priority now for Harvard and its governing boards is making sure that HMS has the resources it requires to take initiatives in research and teaching. HMS is the top medical school. This is the time and this is the place."

Mockler is president and chief executive officer of the Boston-based

Gillette Company. He served as a Harvard overseer and board of overseers' chairman before joining the President and Fellows on Harvard's senior governing board.

Lewis Thomas '37, who shares the chairmanship of the campaign with Mockler, spoke of the need "to do some totally new things about medical education." Noting that the curriculum at most medical schools is "stuffed with biodegradable facts," Thomas added, "Whatever success lies ahead, enabling HMS to make changes that need to be made will depend on alumni and friends who are in this room. I consider this chairmanship to be a social duty and a high privilege, and I thank Dan Tosteson for talking me into it." □



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Katherine Iacocca and Ronald Kahn

Iacocca Proceeds Yield New Professorship

Among the yields of Chrysler chairman Lee Iacocca's best-selling autobiography is the endowment of a new Harvard Medical School professorship. Established for research in diabetes and metabolism at Joslin Diabetes Center, the chair is a gift of the Iacocca Foundation—which is funded largely by royalties from the Iacocca autobiography.

At a ceremony last winter, foundation president Katherine Iacocca presented the professorship in memory of her mother, Mary K. Iacocca, who died in 1983 from complications of diabetes. Lee Iacocca recalled at the ceremony that the Iacocca family began its relationship with Joslin in

1975, when Mary Iacocca became a patient there. "Mary really worked hard at her disease," he said. "Thank God we started here early."

The first occupant of the chair is C. Ronald Kahn, HMS professor of medicine and director of research at Joslin. Since 1970, when he was a senior scientist at the Diabetes Branch of the National Institutes of Health, Kahn has focused his research on the insulin receptor, the cell's binding site for insulin. He and others have found that diabetes can be caused by factors other than disorders in the production and release of insulin. Defects in insulin action at the cellular level, both at the receptor and postreceptor stages, may be significant causes of altered metabolism.

Kahn's investigation of the genetic obesity of mice led to the first descrip-

tion of a receptor disorder. Other such disorders now known include decreased binding of insulin due to fewer insulin receptors (as has been demonstrated in obese people), reaction blockage by antibodies, and genetic defects.

Kahn is currently investigating the signalling mechanism used by insulin at the molecular level. Among his goals—and those of his colleagues—is to learn how to make more insulin receptors.

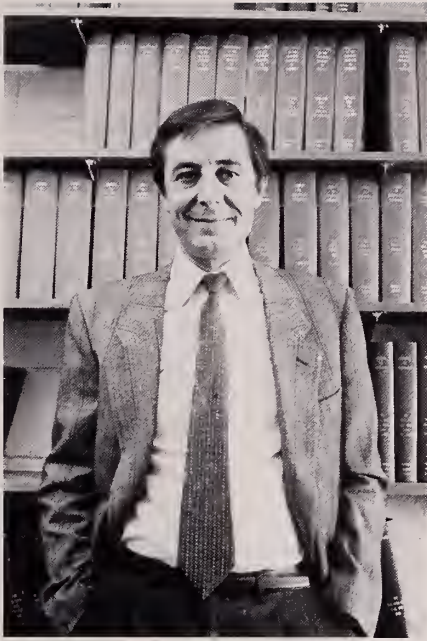
The new professorship is not the first time Joslin has been the recipient of the Iacocca Foundation's generosity. The foundation, which primarily funds diabetes research, has also endowed Iacocca fellowships at Joslin, used to attract new research talent.

At the endowment ceremony for the new chair, Lee Iacocca called the professorship "money well spent," and diabetes research the "best cause I've ever been affiliated with." He noted that proceeds from his autobiography have passed the \$5 million mark. "Diabetics buy the book," he added. "It has developed a new constituency." □

New Leaders for M.D./Ph.D. and HST Programs

This past academic year saw the appointments of new directors for two HMS-affiliated programs. In December 1986, Bernardo Nadal-Ginard became director of the M.D./Ph.D. program. The previous summer, Roger Mark '65 and Richard Kitz were named co-directors of the HMS-MIT Division of Health Sciences and Technology (HST).

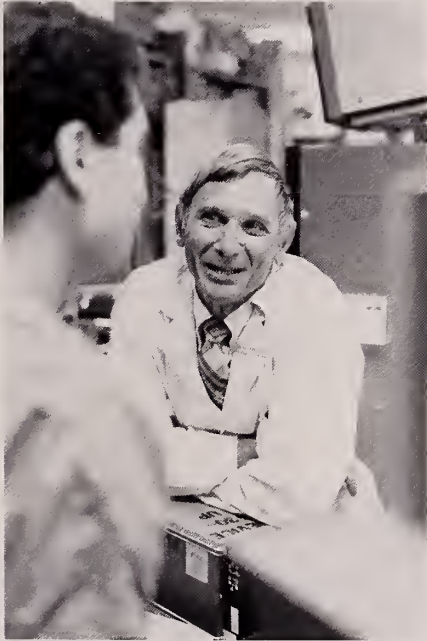
Bernardo Nadal-Ginard is HMS professor of pediatrics and chief of cardiology at Children's Hospital, specializing in the developmental genet-



Bernardo Nadal-Ginard



Roger Mark



Richard Kitz

ics of cardiac and skeletal muscle. He has an M.D. from University of Barcelona School of Medicine in Spain and a Ph.D. from Yale University.

He succeeds Edgar Haber, Higgins Professor of Medicine, who directed the M.D./Ph.D. program for the previous three years.

"I take seriously the challenge to maintain this as one of the best M.D./Ph.D. programs in the country," says Nadal-Ginard. "It is impor-

tant to HMS and to me to educate physician-scientists who will make careers in biomedical research."

Richard Kitz is Henry Isaiah Dorr Professor of Research and Teaching in Anesthetics and Anesthesia at HMS and chief of anesthesia at Massachusetts General Hospital, where he helped establish the Department of Biomedical Engineering. He has been a member of the HST Joint Faculty Committee for five years.

Roger Mark is Matsushita Associate Professor of Electrical Engineering in Medicine at MIT and assistant professor of medicine at HMS. Former director of HST's Biomedical Engineering Center, he has been actively involved with HST's research and educational programs for more than a decade.

Mark and Kitz succeed Irving London—HMS professor of medicine, MIT professor of biology, and Grover M. Hermann Professor of Health Sciences and Technology—who directed HST for the 15 years since its inception in 1970. □

In the Beginning

The number of applicants to Harvard Medical School has dropped by 32 percent over the last 11 years, a figure even more dramatic than the national decline of 25 percent. Nationwide, the decline in numbers of white

male applicants accounts almost entirely for the dwindling pool. (The female applicant pool has increased steadily over the last 10 years nationwide, and began to taper off only last year.) At HMS the statistics are slightly different: the number of female applicants has risen and fallen more closely in sync with the male. The percentage of women in the Class of 1990 (37 percent) is almost exactly what it was five years ago.

Gerald Foster '51, director of admissions, attributes the decline in the medical applicant pool to the long and increasingly costly educational process in medicine relative to other disciplines, and to a vague notion among potential applicants that, in terms of autonomy and income, the life of a physician today "isn't quite what it used to be." He is quick to add however, that HMS still has an abundance of applicants, accepting only one for every 18 who apply.

"We have our usual class of super men and women this year in spite of the falling applicant pool," says Foster. Average scores on the MCAT for the incoming students were a full three points higher than the national average, and, as in previous years, close to 50 percent of the matriculating class had undergraduate grade point averages of 3.75 or better.

The Class of 1990 is 15 percent minority, including 15 black Americans, six Mexican Americans, one Puerto Rican, and one Native American. These statistics are similar to those for incoming classes during the last 10 years. The group also includes 61 women, 5 faculty offspring, and 8 alumni offspring.

The incoming class represents 33 states, Canada, England, Greece, Israel, Lebanon, and the Virgin Islands. As usual, the greatest number of applicants and matriculating students came from New York, California, and Massachusetts. They were educated at 57 different undergraduate institutions, including 40 from Harvard/Radcliffe, 12 from Yale, nine from MIT, and eight from Cornell. Their age distribution is also broad, ranging from 20 to 38.

The great majority (76 percent) of incoming students were science majors. Ten percent were humanities majors, and nine percent came from the social sciences. Non-science majors had a slightly better chance of being accepted than science majors. "Breadth of education and the capacity to pursue one subject in depth



was more important to the admissions committee than undergraduate major," explains Foster. "These students have demonstrated outstanding personal as well as academic strengths. They are all well qualified to enter this very human and caring profession."

Abeliovich, Asa
Herzelia, Israel (MIT)
Albert, Christine M.
Methuen, MA (Boston U.)

Allan, James S.
Pittsburgh, PA (Harvard)

Altshuler, David M.
New York, NY (MIT)

Anderson, Matthew R.
Scarsdale, NY (Columbia)

Atebara, Neal H.
Hilo, HI (Yale)

Barnes, Andria J.
Glendale, CA (Yale)

Barrette, Ernie-Paul
Woonsocket, RI (U. of Rhode Island)

Barton, Mary B.
Maplewood, NJ (Yale)

Berkenblit, Scott I.
North Valley Stream, NY (MIT)

Blazar, Philip E.
Providence, RI (Harvard)

Borud, Loren J.
Minot, ND (Stanford)

Brenner, Adam M.
Orlando, FL (Emory)

Brennick, Jeffrey B.
South Easton, MA (Gordon College)

Burstein, Harold J.
Pittsburgh, PA (Harvard)

Carter, Richard S.
Sherman Oaks, CA (California State College, Northridge)

Cervantes, William G.
Lucerne Valley, CA (California State U., Dominguez Hills)

Chen, Diane L.
El Cerrito, CA (Haverford)

Chen, Kathy I. C.
Rochester, NY (Cornell)

Choi, John C.
Chattanooga, TN (Harvard)

Cohen, Jonathan
New Canaan, CT (Harvard)

Cooley, Vernon J.
Salt Lake City, UT (U. of Utah)

Crane, Alan L.
Rochester, NY (Harvard)

Cranshaw, John E.
Wellesley, MA (Emory)

Cunningham, Miles G.
Mena, AZ (U. of Arkansas)

Dauerman, Harold L.
Fort Lee, NJ (Yale)

Davis, Benjamin T.
Wappingers Falls, NY (Yale)

DeWitt, Dawn E.
Marinette, WI (Mount Holyoke)

Deschler, Daniel G.
Rockford, IL (Creighton U.)

Diamond, Michael S.
Flushing, NY (Columbia)

Dion, Carol A.
Framingham, MA (Mount Holyoke)

Doering, Elana B.
Lutherville, MD (Johns Hopkins)

Duel, Barry P.
Oceanside, NY (Cornell)

Edelsten, Pamela M.
LaJolla, CA (U. of California, San Diego)

Edmond, Byron K.
Atlanta, GA (Morehouse)

Epstein, Judith E.
Union City, NJ (Columbia)

Falk, Melissa J.
Aspers, PA (Pennsylvania State U.)

Faran, Michael E.
Whittier, CA (U. of California, Los Angeles)



Faust, Kathleen S.
Potomac, MD (Johns Hopkins)

Felsen, Ruth B.
Silver Spring, MD (U. of Maryland)

Fischer, Gary S.
Swoyersville, PA (Franklin & Marshall)

Flaherty, Alice W.
Brookside, NJ (Harvard)

Fleishman, Joan M.
Eden Prairie, MN (U. of Chicago)

Forbess, Joseph M.
Jacksonville, FL (Harvard)

Frangioni, John V.
Arlington, VA (Harvard)

Frazier, Daveed D.
Dayton, OH (Brown)

Frohlich, Mark W.
Kinnelon, NJ (Yale)

Gallagher, Thomas H.
Claremont, CA (Carleton College)

Gandhi, Rajesh T.
Salt Lake City, UT (U. of Utah)

Gill, Thomas J., IV
Pittsburgh, PA (Harvard)

Glaser, Nicole S.
Miami, FL (Swarthmore)

Gomez, Martha
Chicago, IL (Lake Forest College)

Green, Jennifer S.
No. Brunswick, NJ (MIT)

Gudas, Thomas F.
Horseheads, NY (Williams)

Hajjar, Roger J.
London, England (Johns Hopkins)

Hanchak, Nicholas A.
Moscow, PA (U. of Scranton)

Hasserjian, Robert P.
Manchester, NH (Yale)

Hawkins, Douglas S.
Wilmington, DE (William & Mary)

Haymes, Allyson A.
Almond, NY (Alfred)

Heher, Eliot C.
Princeton, NJ (Harvard)

Hirschhorn, Joel N.
New York, NY (Harvard)

Holder, David W.
Brooklyn, NY (City College, CUNY)

Hostetler, Anne M.
Goshen, IN (Goshen College)

Hung, Rebecca R.
Wheaton, IL (Harvard)

Jaffe, David L.
Wilmington, DE (U. of Pennsylvania)

Johnson, Mark D.
Memphis, TN (Amherst)

Kaji, Eugene H.
Philadelphia, PA (Harvard)

Kang, Sang-mo
Fairfax, VA (Cornell)

Kanter, Andrew S.
Moraga, CA (U. of California, Los Angeles)

Kim, Charles B.
Kirkland, WA (Stanford)

Kim, Saechin
Long Island City, NY (MIT)

Kim, Young-Jo
Western Springs, IL (MIT)

Kimberg, Leigh S.
West New York, NJ (U. of Pennsylvania)

Kinota, Stanislaus
Oakland, CA (U. of California, Berkeley)

Koh, Theodore J., II
Rockville, MD (Cornell)

Kohn, Melvin A.
Roslyn Heights, NY (Yale)

Kolodny, Rebecca S.
West Newton, MA (Harvard)

Kunz, Victoria S.
Mattapoisett, MA (U. of Delaware)

Lee, Burton W.
Fountain Valley, CA (U. of California, Los Angeles)

Lee, Frederick S.
Kensington, MD (Harvard)

Lee, Kenneth C.M.
Honolulu, HI (Harvard)

Leonard, Claudia S.
Chevy Chase, MD (Harvard)

Levin, Jennifer A.
New York, NY (Yale)

Lewin, John M.
Denver, CO (Harvard)

Lewin, Rebecca Shore
Needham, MA (Harvard)

Lin, Eva I.
Wilmette, IL (Harvard)

Lindsay, Mary L.
Portsmouth, VA (U. of Virginia)

Liu, Jessica
Princeton, NJ (Harvard)

Lukaszewicz, Gregory C.
Williamsville, NY (Dartmouth)

Marroquin, Edmundo
Oceanside, CA (U. of California, San Diego)

McCarthy, Sara J.
Hingham, MA (Yale)

McGehee, Margo A.
Pasadena, CA (Smith)

Mitchell, Matthew E.
Prairie Village, KS (U.S. Air Force Academy)

Moore, Jude J.
Berkeley, CA (U. of California, Berkeley)

Morgan, Jeffrey A.
Gladwyne, PA (Harvard)



Morse, David S.
Needham, MA (Brown)

Moulton, Michael J.
W. Des Moines, IA (Amherst)

Mun, C. Edward
Torrance, CA (Yale)

Murray, Megan B.
Minneapolis, MN (Dartmouth)

Nardin, Rachel A.
Milwaukee, WI (U. of Chicago)

Nash, John P.
Glendale, CA (U. of Southern California)

Need, Laura R.
Durham, NC (Wellesley)

Newman, Emily B.
Chestnut Hill, MA (Barnard)

Noronha, Michael A.
Pelham Manor, NY (Fordham)

O'Neill, Mary J.
Concord, MA (U. of Pennsylvania)

Ott, Ingrid L.
Skillman, NJ (Harvard)

Pangie, Caroline A.
Schenectady, NY (Union College)

Patton, Marvin C.
Oakland, CA (Peralta College)

Paul, Laurence E.
Pittsburgh, PA (Harvard)

Pechet, Tiron C.M.
Cambridge, MA (Harvard)

Pelidis, Maria A.
Rhodes, Greece (Wellesley)



Peregrino, Manuel A.
Austin, TX (U. of Texas, Austin)

Pierce, Eric A.
New York, NY (Dartmouth)

Pierluissi, Edgar
Chicago, IL (U. of Chicago)

Pion, Ira A.
Oceanside, NY (Cornell)

Plews-Ogan, Margaret L.
Crystal Lake, IL (College of Wooster)

Pomerantz, Daniel H.
Great Neck, NY (Columbia)

Potter, Michael B.
Las Vegas, NV (Harvard)

Powell, David E.
New York, NY (Harvard)

Pugh, Guy F.
Canton, MA (Wesleyan)

Ralph, Walter M.
Bronx, NY (City College, CUNY)

Reynolds, Eileen E.
Lexington, MA (Harvard)

Rising, Catherine L.
Farmington Hills, MI (U. of Michigan)

Robb, Erica
Brookline, MA (Princeton)

Rosenfeld, Anne H.
Berkeley, CA (Haverford)

Rosner, Mitchell H.
Roslyn, NY (Harvard)

Ruth, Robert M.
Telford, PA (Franklin & Marshall)

Rutledge, Tanya M.
Norris Plains, NJ (Stanford)

Sanger, Terence D.
New York, NY (Harvard)

Satcher, Robert L., Jr.
Nashville, TN (MIT)

Schaffer, Cynthia A.
Shaker Heights, OH (Harvard)

Scheindlin, Benjamin
Philadelphia, PA (U. of Pennsylvania)

Schmitt, William P.
Novato, CA (Yale)

Schwartz, Marc S.
Glenside, PA (Wesleyan)

Senkowski, Christopher K.
Farmington Hills, MI (U. of Michigan)

Sguigna, Carla L.
London, England (Franklin & Marshall)



Shand-Kovach, Ian
Topeka, KS (MIT)

Silverman, Lewis B.
Brockton, MA (Harvard)

Slanetz, Priscilla J.
Locust Valley, NY (Smith)

Socher, Steven A.
The Woodlands, TX (U. of Texas, Austin)

Sprauve, Margaret E.
St. John, Virgin Islands (U. of Detroit)

Stasior, David S.
Liverpool, NY (Cornell)

Staub, Ariane
Groton, MA (Princeton)

Stone, John H., Jr.
Tucker, GA (Emory)

Strong, Willie F.
Newman, GA (Emory)

Stroud, K. Lisa
Clarks Summit, PA (Cornell)

Sutton, Eliza L.
Palo Alto, CA (California Institute of Technology)

Tanaka, George
Cincinnati, OH (Princeton)

Tancredi, David N.
Rochester, MN (Harvard)

Taratuta, Elena G.
Brookline, MA (Harvard)

Terrazas, Ramon J.
Oakland, CA (U. of California, Berkeley)

Ting, Henry H.
Dunkirk, NY (Cornell)

Trevino, Anne
Santa Monica, CA (Vassar)

Umlas, James W.
Cambridge, MA (Harvard)

Weinfeld, Mark S.
Newton Centre, MA (Harvard)

Weiss, Lisa K.
Wilmette, IL (Stanford)

Welsh, David K.
Cambridge, MA (Stanford)

White, D'Juanna O.
Mount Vernon, NY (MIT)

Williams, David E.
Toronto, Canada (Princeton)

Wolf, Nancy G.
Shaker Heights, OH (Harvard)

Woroncow, Halina
South River, NJ (Oberlin)

Yee, John D.
Fridley, MN (Harvard)

Yi, Tau-Mu
Charleston, SC (Harvard)

Yu, Debra
Williamsville, NY (Princeton)

Zaragoza, Bernard J.
Miami, FL (U. of Miami)

Zwas, Donna R.
Southfield, MI (Barnard)

BOOK MARKS

One From the Heart

TAKE HEART: THE LIFE AND PRESCRIPTION FOR LIVING OF DR. PAUL DUDLEY WHITE, by Oglesby Paul, M.D., Harvard University Press, Boston, 1986

by Thomas W. Smith '65

In his long and active life, Paul Dudley White did an enormous service for the cause of world peace and understanding. He conveyed, in his words and actions, the simple message that physicians—indeed all persons devoted to the care of the sick—can maintain fruitful dialog about issues of health care that transcend political and ideological barriers between nations. A premier cardiologist and teacher of cardiology, White was a founding father of the American Heart Association.

Despite the national and international prominence White achieved as personal physician of president Dwight D. Eisenhower and as universally respected ambassador of international good will, the details of his life and work have never been told in a comprehensive biography until now.

We are indebted to another distinguished cardiologist, Oglesby Paul '42, for *Take Heart*. This lively and informative biography traces the life of Paul Dudley White from his birth in Roxbury, Massachusetts, in 1886. It follows him through his early years under the influence of his father, Herbert Warren White, a hard-working general practitioner and devout Baptist. Herbert White played a major role in the founding of the New England Baptist Hospital and was also a lecturer and later professor of medicine at Tufts Medical School.

Generations of physicians who worked with and learned from Paul Dudley White at Massachusetts General Hospital already know the story of his early training with Sir Thomas Lewis in London, and of his 1914 introduction of high-tech cardiology

to Boston in the form of the string galvanometer electrocardiograph.

The account of White's formative years may be new and particularly compelling in providing a vivid background against which both the man and his contributions stand out. Also of particular interest are the detailed accounts of White's role in caring for Eisenhower during that president's heart attacks in the 1950s and his dramatic visit to the People's Republic of China in 1971.

Oglesby Paul relates these aspects of White's life and times without neglecting his monumental contributions to the art and science of clinical cardiology. He clearly delineates White's leadership in establishing the research mission of the American Heart Association, his guidance in developing its priorities, and his immense influence in advocating a prudent diet and physically active lifestyle—at a time when these now well-accepted principles for reducing cardiovascular risk were widely neglected.

In this superb biography, Paul draws on his extensive knowledge of White as a personal mentor in cardiology and a long-time colleague and friend. Yet Paul has the perspective to paint a full picture that includes the human side (and even a foible or two) of the man even as he presents White's service to medicine and to humanity in general. The book is written with an elegant economy of style that will come as no surprise to those privileged to have worked with and learned from its author.

Those who knew Paul Dudley White, and a subsequent generation who know the people and institutions with which he was associated, should spend a few delightful hours with this book. All who care for the sick will find inspiration in this perceptive account of the life of a Harvard Medical School alumnus and faculty member whose influence was, and is, felt worldwide.

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When Doctors Get Sick

Lessons learned from stories of illness

by Howard M. Spiro

Over the past few years, a colleague and I have been collecting the stories of doctors who have been sick. Curiously, such tales are not easy to find. Doctors write case histories willingly enough and report research enthusiastically, but they rarely write stories about their patients and they almost never write about their own illnesses. That is too bad, for what doctors learn when they are sick can help us all improve the care we give and think more resolutely about how we live as doctors.

What sick doctors have to say about the treatment they've received may help improve medical care; what they do *not* say may make us wonder about how we train people to give clinical care.

I have looked in the stories for clues to how I may, somehow, come to terms with illness and disability, retirement, and impending death. I share the idea of many psychiatrists and poets that we all suppress the fear of death so we can take some joy in our world. Doctors, I suspect, have that fear stronger than most and repress it the best, thanks to their training.

Doctors who have written about themselves on their own are rare in the mainstream of medicine. For most

physicians, illness and disease have become such everyday experiences that there seems no reason to write up anything but its science. Moreover, the tradition that has led our profession to shun public expression of personality or grievances has only recently been discarded. The anecdote is meaningless, we are taught, and the personal story in newspaper or magazine has until recently been seen as eccentric or self-seeking.

Our medical language helps keep doctors from writing about sick people. Technical jargon much of the time, medical writing uses abbreviation and clichés to convey "facts," not feelings. Case reports describe diseases, not people. The phrase "a 60-year-old WD/WN white male" hides any hint of character or accomplishment. From the patient we extract the case. The sonogram shows the flow of blood but not the real heart.

Practicing physicians usually feel they need to maintain an aura of perfection, that the doctor who talks about being sick will lose his or her practice. Reliability and availability are key. A middle-aged pediatrician in a small Connecticut town who developed Parkinsonism was sure that his mind and judgment were as good as ever, but he feared that his patients might leave a doctor "less than per-

fect." To play the role of omnipotent healer, the physician must seem immune to disease. Patients and colleagues have an almost magical need for a healer who remains well and will be there when needed.

Illness can provide time for reflection to doctors who will take it. In his book *Creative Malady* (Oxford University Press), George Pickering calls his osteoarthritis an "ally." He writes, "When [my hips] get intolerably painful, I put them to bed. In bed I cannot attend committees or see patients or entertain visitors. But I can read or write or dictate. . . . These are the ideal conditions for creative work." Pickering finds that for creativity the best illness is one "that is not debilitating or disabling," for too severe a disease, "gives rise to fear, which tends to monopolize the mind and to displace productive activity."

It is usually the alienated, the unsuccessful, the dissatisfied, or those few whose creative impulses have been awakened by illness who write. If illness or coming to terms with illness leads to creativity, as is generally assumed, then the healthy physician is unlikely to become a writer.

It has been said that William Carlos Williams was not a good doctor. For poetry in medicine, we may need a new specialist at the margin

like an ethicist—a hospital esthetician to connect medical practice with philosophy, to reawaken us to the passion of practice.

Most doctors are interested in science, not humanities. Our grades in science and our ambition get us into medical school. Our achievements and our energy count for more in that process than any tendency to introspection. Physicians learn to measure, not conjecture—to act, not reflect. The pace in medical school and professional life seldom leaves time for contemplation.

We doctors may be less sensitive than others to the drama around us because we are so familiar with it. We have so much to do. The sick poet can make a glass fang sucking blood out of a syringe; the novelist stripped for an operation can see the surgeon in clerical garb crowned with a skullcap. Such reveries escape the more literal physician. Doctors working away from the sick at medical research spend their time at the bench—creating, working with techniques.

In love with health, we doctors can find no good in our rival—our enemy even—which is disease. We do not wish to soften that enemy by blurring his lines. We have only to conquer. Where a Japanese writer can see chrysanthemums in a tumor-ridden liver, the physician sees a cluster of malignant cells to be destroyed.

Armchair reflection in medicine is usually preceded by apology, rarely supported by grants, and generally considered the harmless stirrings of senescence. The macho ethos of medicine calls for doing, not thinking. Physicians see too much suffering and learn too much about their fellows to let their imaginations run. If they did, they might never return to the hospital or office.

For doctors, there is no catharsis beyond cure. Sick, the doctor can only hope to return to good health. To change is to yield, to get less than

a cure. We want a return to the status quo, not to any altered and improved state.

For others, disease may open new insights into the beginnings of a new life; for physicians, disease puts on only blinders. To triumph is to overcome disability, to win a victory by work, to persist, but not to think too much.

The trained detachment of our profession has a part in the physician's reaction to his or her illness. Physicians cannot allow themselves

his colleagues' questions about his increasing limp and his cane. Queries of concern gradually ceased and "were replaced by a very obvious desire to avoid me."

He only guesses that his colleagues were respecting the defenses he erected and he laments his isolation: "I have received relatively few telephone calls or letters from the scores of colleagues I have met in more than 20 years of academic life."

One otherwise sensitive doctor doubts in his sickness that anyone can understand the patient. "Physicians and nurses, however much they

strive to understand the total patient, may only comprehend something of his brain. . . . it is impossible for a physician to reach inside a patient's soul. . . . During recent treatment, a young, talented, bright, healthy physician said to me, while I was in the depths of my own sadness, 'I know just how you feel.' I found myself suddenly angry, pointed my finger at him and said, 'The hell you do.' " (Papper, S. "Care of Patients with Incurable, Chronic Neoplasm—One Patient's Perspective."

American Journal of Medicine 78, 1985.)

After so many years of teaching others to take care of patients, he had no confidence that anyone can know the heart and soul of another. Empathy for him was a metaphor, not a reality.

Most sick doctors try hard to be "good" patients, which means not complaining. To a large extent American medicine has taken on a Calvinist cloak. Many physicians don't know how to deal with emotion, in patients or in themselves. The good patient is docile and does what he is told. He or she may suffer, but does not complain. The impersonal nature of our hospitals and offices reaffirms that message. It is easier for the doctor to examine the X ray or scan than to listen to the patient. Control trials



THE DOCTOR TURN'D PATIENT.

Or the Physician forced to take his Own Stuff.

Published 15th May 1794, by LAURIE & WHITTLE, N^o 53 Fleet Street London.

to get too involved with their patients. For as we leave one sick room, we enter another. If you get too involved, a little bit of you dies with each patient. That protecting distance can become a manner and that manner can become ourselves.

Most physicians believe themselves invulnerable. That fear lies on the other side of our strength is obvious. Invincibility goes hand-in-hand with denial.

Denial comes out as detachment and both often lead to isolation. Endocrinologist D. Rabin describes in *The New England Journal of Medicine* how he and his wife decided to avoid the disclosure of his amyotrophic lateral sclerosis for as long as possible ("Compounding the Ordeal of ALS—Isolation from my Fellow Physicians," *NEJM* 307, 1982). He turned aside

The sick doctor is like the football coach who hasn't played in years. To have linemen rushing at you is quite different from calling the plays from the sidelines.

reinforce the foolish idea that all doctors are equivalent and only the procedure or the drug changes.

Surely, the equanimity that doctor-patients so often portray cannot represent simple confidence in what medical practice can do. Physicians know the complications; we are aware of the disasters. Occasionally, doctor-patients rebel, cry out, leave the hospital early, or ask for second or even third opinions. That special sense of fear remains and summons denial. Most doctors who are sick try to suffer in silence.

Many modern practitioners ignore symptoms for more objective evidence of disease, thinking that complaints provide information less reliable than the hard copy of image or laboratory number. But when they fall sick, many doctors are delighted to discover new diagnostic clues in their own symptoms. The sick physician finds an exquisite awareness of his or her complaints even when he or she tries to ignore them.

When the sick doctor finally looks for help, the doctor's doctor finds no easy task. The usual patient needs our technical competence, but the doctor-patient may think he or she knows what we know and often has a diagnosis in mind, sometimes the wrong one. The ordinary patient has confidence in the physician's skill, but the physician-patient has training which may get in the way. He or she never really accepts, and never really is given, the total sick role.

No one trains to be a doctor's doctor. You learn on the job, unlike the Pope's confessor who gets special training for his unique role. For the doctor's doctor and his or her patient, there is always a sense of fraternity.

Recently, I saw a 39-year-old physician with stomach cancer that had spread to several nodes. I was aware of a special sense of involvement because a colleague, supposed to be

well and healing others, was so struck down. He might have been me. I might have felt the same anguish at the plight of any 39-year-old, poet or professor or friend, but there was an immediate merger of identities with a physician.

We know him. We know what he knows. He knows what we know and what we may hide from other patients. To talk of cancer chemotherapy with the physician who has studied, and sometimes misunderstood, the literature is to find that the net of hope we spread out under other patients has holes we cannot patch.

For other people, getting sick is a mysterious amalgam of anxiety, fear, discomfort, and hope. The doctor who falls sick is like the football coach who has not been a player for years. To have the opposing linemen rushing at you is quite different from calling the plays from the sidelines. When a doctor gets sick, the setting does not change, but he or she is suddenly on the other side of the doctor's desk.

Physicians are accustomed to being in control—the result of habits of many years supported by the usual ready submission of the sick. The physician-patient wants to remain in control and the doctor's doctor knows it. The radiologist reads her own films, the gastroenterologist scrutinizes his cecum, with some help. Physicians who try to remain in control of their care forget the clouded judgment of the sick and how wrong their choices may be.

Autonomy may be lauded for modern patients, but it is not something the sick physician usually chooses for himself once he has found a doctor.

Sick doctors want to be taken care of, even if they try to remain in control; they find the most relief when someone else takes over. Here we are, a group possessed with special knowledge, often trying to exert control beyond the bounds of reason, and yet, almost to a man or woman, wanting to be cared for, have decisions

made for us.

Most doctor-patients stress the alienation of being a patient. Neurologist Oliver Sacks in *A Leg to Stand On* remembers his months as a patient: "But if I rejoiced in the blessing of the sun, I found I was avoided by the non-patients in the gardens—the students, nurses, visitors who came there. I was set apart, we were set apart, we patients in white nightgowns and avoided clearly . . . like lepers. . . . I realized how I myself, in health, in the past, had shuddered away from patients quite unconsciously, never realizing it for a moment."

The past decade has seen "telling the truth" sometimes become more important for doctors even than taking care of patients. But unvarnished truth is not always welcome to sick doctors, who may prefer it covered by ineluctable compassion. We want faith, hope, and kindness. All sick doctors come down on the side of hope and optimism. No one suggests that we doctors should lie to our patients, but most of us seem to agree that hope, consolation, and an optimistic outlook can do no harm.

The stories of sick doctors provide models not only of how to be a patient but of how to be a doctor. The story of a sick doctor is a guide. If we cannot talk about our colleagues and, more important, with them, how can we talk with our patients?

The message from the sick doctors whose stories I've read tells us that hope helps as much as truth—and that imagination, drama, passion, and even poetry are as important in medical practice as they are in the rest of life. Sick doctors remind us we are all links in a chain and that just as I am a father and a son, I am a doctor and will someday be a patient. Our lives run along a precipice that separates life from death. □

Howard Spiro '47 is director of the Program for Humanities in Medicine at Yale University School of Medicine, professor of medicine at Yale, and former chief of Yale's Gastrointestinal Unit. This piece was adapted from the first Zachary M. Kilpatrick Lecture at the Medical College of Georgia in September 1986. It appears here with permission of Perspectives in Biology and Medicine, which will print a version of this article in an upcoming issue. A version will also appear as the epilogue in an upcoming book on doctors as patients edited by Spiro and colleagues.

Finding Creativity in Adversity

*A surgeon ponders the truths and consequences
of three episodes of illness*

by Joseph Murray

I have long been struck by the idea that adversity can bring out the best in people. A sudden physical disability, although seemingly catastrophic, may prove to be a stepping stone toward wider horizons. During my life, three disastrous, and potentially life-threatening, illnesses have been the occasions for positive, creative change.

I've always been a physical culture enthusiast, considered by some a nut. As a camp counsellor during my college years, I ran and swam several miles before breakfast; during medical school I played squash and worked out daily in the Vanderbilt Hall gym; as a surgical intern at the Brigham, I regularly played tennis by day or squash at night. Challenging my resident to find unfinished chores of mine became a game. He loved to bellow across the tennis court, "Murray, you didn't write the white count on so and so's chart! Hop to it, White Suit!" I'd then challenge him to find incomplete work.

I loved vigorous physical exercise and never worried about my health. My weight has not varied by more than a pound or two since high school. During my surgical residency after World War II, I revelled in long hours of work and short hours of sleep. It

was a glorious opportunity to be part of a university hospital, practicing on the leading edge of surgical progress. There was a subliminal satisfaction at being an iron man.

In 1949, when I was 30, something occurred to alter my perspective. I was in the final year of my general surgical residency. At the end of an extremely tiring day, while I was scrubbing for an acute abdominal emergency, my pregnant wife phoned to notify me of increasingly frequent labor contractions. Our only child was in the care of in-laws in a distant city; she was home alone in our nearby apartment.

Instead of asking an attending surgeon to take over my duties, with false pride and a hypertrophied sense of duty, I proceeded with the laparotomy and removed a complicated retrocecal appendix. Two hours later, I picked up my wife and drove her to Boston Lying-In Hospital.

By then I had been working continuously for 20 hours, and I returned to the Brigham for sleep. Two hours later, I awoke with severe anterior chest pain radiating to the back. I still remember my ecstatic pain relief that followed an injection of 100 mg.s of Demerol. An EKG showed a depressed ST segment, so I was hospi-

talized with a diagnosis of acute myocardial infarction under the care of cardiologist Samuel A. Levine.

The next morning, my wife delivered a healthy baby girl. Francis D. Moore '39, recently appointed surgeon-in-chief, and his wife Laurie, oversaw the care and concerns of both hospitalized parents. My wife and daughter were discharged seven days later. I saw my child for the first time on Ward C-3 when they visited on their way home. I was hospitalized for three weeks. It seemed strange to me to be physically disabled, but I recall telling Carl Hoar, a fellow resident, that I'd just have to accept and make the best of the situation.

The resolution of the clinical course and the EKG patterns were not typical. Sam Levine ultimately signed me out as "acute pericarditis." Nevertheless, I took a month's rest followed by another month of limited work. I gradually and cautiously resumed a full schedule, including squash and tennis.

One year later I asked Dr. Levine if I should have regular follow-up EKG's for the rest of my life. "No!" he answered decisively, "Forget the entire episode."

It was wise advice. With a different admonition, I might have become

a cardiac cripple; one never knows. Nevertheless, forgetting such an episode is easier said than done; its imprint has remained in my mind and has altered my lifestyle ever since. I no longer take life and health for granted. I know now that I am not indestructible. Every day is a precious gift.

During the next 12 years, I developed a busy surgical practice, an extensive research program, national and international commitments, an increasing teaching load, and greater family responsibilities. Always careful about my health, I exercised regularly at competitive tennis, skiing, back-packing, and mountain climbing. Remembering my earlier brush with illness, I tried to achieve a more balanced lifestyle, with adequate sleep and proper vacations.

In July 1961, I went camping with my wife and five children in the maritime provinces of Canada. I had completed the purchase of a larger home for our growing family in June, our old house was being sold, and our moving date was set for August 25.

In early August, my family visited my wife's parents in New York while I attacked a heavy daily operative schedule, planned the laboratory program for the coming academic year, and prepared grant applications. After all, I was only 42 years old and in the competitive arena of university surgery.

There had been an epidemic of the flu in Boston that summer. I had had some mild but annoying symptoms, including a headache. But on our moving day, while I was operating on an extensive facial cancer, my headache intensified alarmingly. My head felt as if it would blow off and burst. I was able to continue just long enough to complete the critical portion of the operation. I left as soon as the patient's safety was assured.

Kendall Emerson '33 and Rick Tyler hospitalized me on Ward A-3. My temperature was 104 degrees; lumbar puncture revealed elevated protein without cells. The tentative diagnosis was viral encephalitis. The next morning I felt better and the following day I was ready to be discharged.



In the early morning of the day of the planned discharge, I bumped into the side of my bed on the way to the bathroom. Surprised, I analyzed my clumsiness and discovered to my dismay that I had no vision on my left side—a complete left homonymous hemianopsia. I suspected the worst: brain tumor or total paralysis.

Of course, I should have informed my doctors of this new finding, but I realized that if my doctors knew, they would keep me for further tests. I wanted to be with my family and help settle our new home.

Because my headache and fever had gone, I kept my newly discovered symptoms to myself and went home. On follow-up exams, Tyler documented severe constriction of all my visual fields. Fortunately, however, my vision gradually improved, and in six months my visual fields were back to normal.

This episode was really frightening. I was in mid-career with pressing responsibilities, both professional and family. The fragility of health and the preciousness of life were reinforced in my mind. In my strivings I had misplaced my priorities. I vowed this time to set them straight.

For the next 25 years, I remained in excellent health. Still a physical fitness nut, I played singles tennis competitively, climbed the Matterhorn at age 52, hiked, canoed, skied, climbed stairs two at a time, and avoided elevators. My professional responsibilities increased yearly. I had a larger staff, more complex surgical operations, more clinics to manage, and more demanding travel obligations.

I was 67 years old when another health crisis occurred in the spring of 1986. My successor as chief of plastic surgery was to arrive in only three months. Not wishing to leave a disorganized service with low morale, I reluctantly had accepted several unappealing assignments and obligations. In a phone call to my daughter in California, after staying up until after midnight working the night before, I mentioned how much I was looking forward to summer vacation and release from responsibility.

I had become overly involved with various activities—the HMS Alumni Association, organization of a craniofacial center at the hospitals, a Massachusetts conservation group, and a zoning controversy regarding illegal helicopter landings on Martha's Vineyard. In the back of my mind I wondered if it would have been wiser to have made a clean break from everything a year or two earlier.

At 6:00 A.M. on the morning of March 20, 1986, I was feeling fit and chipper and looking forward to a day's busy schedule—which included finishing a manuscript, hospital rounds, tennis at noon, and a flight to a distant medical school for three days of lectures. In the shower, I reached for the temperature control and tossed my head backwards to receive the pleasure of the water splashing on my chin and neck.

Suddenly, I had a strange feeling in my left calf and leg that I had never felt before. It didn't feel like a muscle cramp. It was more like a weakness. Could it be...? Within seconds I had the same sensations in my left arm and forearm. It was too coincidental to have muscle cramps and spasms in both left extremities in such a short span of time. It must be cerebral in origin, I thought. Let's

hope it goes away. My left foot became clumsy as I tried to step over the tile curbing of the shower door.

Hoping against hope it would all disappear like a bad dream, I got myself dressed. As I buttoned my shirt and tied my necktie, I had no doubt that something serious was going on. The entire left side of my face tingled and my left hand became numb. I lay down while my wife called Rick Tyler. At his suggestion, I breathed into a paper bag. At 9 A.M. my wife drove me to the hospital. When I arrived, I reluctantly but gratefully used a wheelchair.

A CT scan showed no hemorrhage but a lesion in the upper pons at the base of the cerebellum. Intravenous heparin was started. By 4:00 P.M., my left side was completely paralyzed, with total numbness of the left face and body. All motions were ataxic. Then the facial numbness started to cross the midline to the right of my oral commissure.

My thoughts were surprisingly calm. At least all six children were educated, and the home was mortgage free. There were no financial worries. Tennis, windsurfing, mountain trekking, wood-splitting, and brush clearing might no longer be possible. I might be confined to a wheelchair. If so, I thought, I'd better start to adjust right away.

Lying in my hospital bed, unable to feel or move the left half of my body, I tried to think of how to best use the rest of my life. I remembered Harold Russell, a World-War-II patient of mine—a bilateral hand amputee—who later became an Oscar-award-winning actor. "What really counts," Harold had decided, "is not what's missing, but what you still have." Harold had made the best of his residual resources. So would I.

I also thought about my friend Philip Sandblom, who had written a book entitled *Creativity and Disease*. I decided to make my illness a positive influence in my life. I would end up with a richer, fuller, more sensitive, and understanding mind. The disease would be creative, not destructive.

The prospect of quitting surgery didn't bother me much. After 42 years in operating rooms, I felt another four or five years would add very little. I did have plans for surgical refinements and new approaches to facial reconstruction, but my younger staff was skilled and capable. I actually felt pleasure at the prospect of canceling all my committee and patient activities, except for my work with

Lying in my hospital bed, unable to feel or move the left half of my body, I tried to think of how to best use the rest of my life.

craniofacial patients, who are so needy and such a challenge. I hoped to continue work for HMS to repay partially my debt for all that institution has given me over the past 46 years.

By Friday noon the following day, there was movement in my left hand. A repeat CT scan categorically ruled out intracranial hemorrhage, but added nothing new. The tentative diagnosis was now infarct or embolus. I continued to improve by the hour.

The initial challenge was to direct my consciousness to the anatomical part I wanted to move. With the entire left side of my body insensate and motionless, I looked to the toes on my left foot and tried to move them. It was such a mental effort to get the signal through that my brain actually became fatigued.

Relearning to walk required prolonged and tiring mental direction. I had to tell myself continuously to move the left arm, next the right foot, then the other extremities in sequence. My brain tired well before my muscles did. I just couldn't keep my attention on the job.

By Saturday morning I could move my left hand and foot slightly. On Sunday morning I stood up and took a few hesitant steps, but was amazed at how difficult it was! Monday, I walked with human support; Wednesday I used crutches. By Thursday, my numbness had disappeared completely and practically all my motions had returned. By Friday, eight days after the episode, heparin was discontinued, and I started climbing stairs.

Nine months have elapsed. My recovery is almost complete. A slight incoordination of the muscles of the left hip and shoulder are the only residual symptoms.

Although never one for introspection, regret, or self-pity, I felt a need to put these facts on paper, possibly as a form of self-administered psy-

chotherapy. Now that I am able to review these episodes of illness, I see they occurred during periods of multiple deadlines and obligations. Had I been acting unwisely in my incessant physical and professional strivings?

Increased susceptibility to infection during periods of stress may have caused the first two illnesses. The particular viruses probably determined which organs became involved. The third illness is harder to decipher. I was not hypertensive or overweight and had normal blood chemistries. No source of embolus was found, although a plaque from a vertebral artery could theoretically have been dislodged by my activity in the shower.

I have no complaints or regrets. The last episode has given me a clean slate for the rest of my life. Without it, I doubt I would ever have had the wisdom to prioritize my future as firmly as I am now. Aware that I've had a full life, a happy family, and undeserved God-given talents, I feel now that my obligation is to use the rest of my life with consideration first to my wife, next to the family, and third to society and my profession.

During my latest attack, tears were shed by everyone involved. As each child visited, I could detect their sorrow. After each left, I myself had a few such moments. But in the long run these illnesses held for me a message about human nature from our Creator: we are not indestructible. There are limits, but we can make episodes like these "creative." □

Joseph Murray '43B is perhaps best known for performing the world's first successful kidney transplant between identical twins in 1954. Also a leader in major craniofacial plastic surgery, he is former director of the HMS Surgical Research Laboratory and of the Craniofacial Program at Brigham & Women's and Children's hospitals. He is now chairman of the HMS Alumni Fund.

The Medical Student and the Frog Baby

*In a New Pathway case study, a father
recalls the birth of an anencephalic child*

by Robert Lawrence

In the following case study, Bob Lawrence '64 recalls, in the third person, the experience of having an anencephalic baby. Used as a reading to generate discussion in New Pathway tutorials, the piece was assigned in the curriculum to coincide with the due dates of pregnant women followed by New Pathway students. Among the issues the case raised in discussion were loss of pregnancy, care of family units as well as individuals, changing attitudes toward sex roles in ob/gyn, giving and receiving bad news, and the way a physician experiences medical misfortune. In the accompanying sidebar, Lawrence explains how he came to write the case. Lawrence is Charles S. Davidson Associate Professor of Medicine, director of the HMS Division of Primary Care, and director of medicine at Cambridge Hospital. All names in the case have been changed.

David Cantrell put the phone down slowly and puzzled over the word his wife Carolyn had just used. "Hydramnios, I think that's what she said," he mumbled to himself as he walked back into the lab of the Renal Division at the Brigham.

He felt anxiety knotting his stomach as he searched his memory for some clue about the word. Carolyn was close to term and had had a routine prenatal visit at the Resident's

Clinic of the Boston Lying-In that morning. David had interrupted his work in the late morning to check in with her and find out how she was doing, expecting a report from the obstetrician about the baby's position, whether the head was engaged, how much longer it might be. From the tone of Carolyn's voice he knew right away that the visit hadn't been routine.

Carolyn had told him that the resident, Patrick Gage, whom she had

seen only once before during one of her first trimester visits, had sent her for an X ray, "Just to check that everything's ok. You don't need to wait around; I'll let you know what it shows."

Now David felt the need to be reassuring and said, "I'm sure he wouldn't have sent you home if he had been worried about the baby." But that strange yet familiar word "hydramnios" troubled him to the core. Had he heard it during the first year in growth and development or just this past year during general pathology?

David returned to the lab bench where he and a classmate had been working all summer attempting to measure the movement of various sized molecules across the peritoneum. Glen was hunched over one of the small chambers, attempting to position a fresh surgical specimen. He and David shared responsibility for speaking to the surgeons each day about their need for several square centimeters of fresh peritoneum to conduct their experiments. Today had been Glen's turn to hang around the operating room and position himself by the room where an abdominal incision was anticipated. David often felt uncomfortable about this part of the project. Somehow he felt exploitive as the surgeon paused in the midst of a sub-total colectomy or cholecystectomy to snip out a piece of tissue for two second-year medical students.

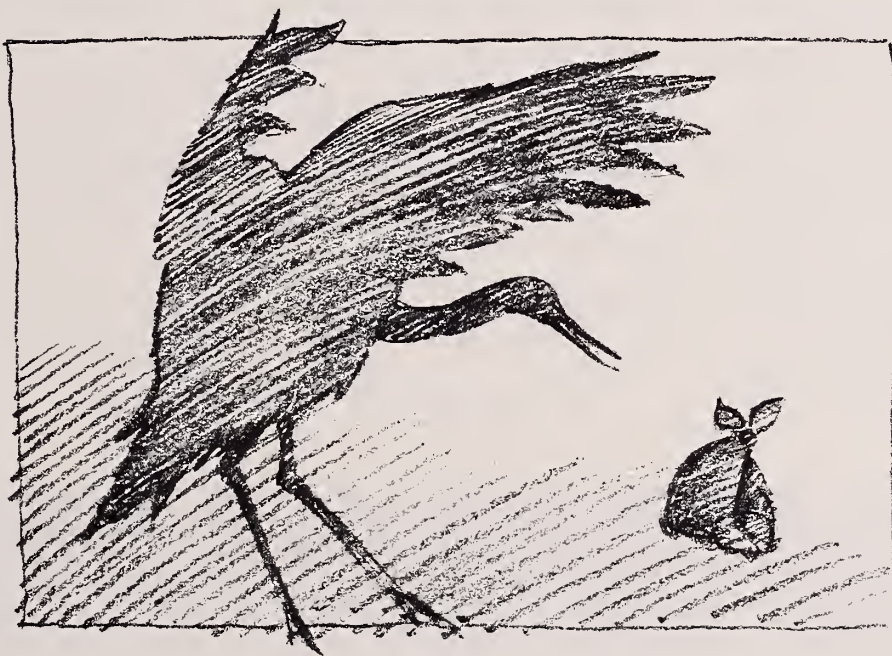
Now David knew that he would be of no use to Glen and said, "I've got to look something up in the library. I'll be back before lunch."

The walk to the library took less than three minutes, and David was panting after taking three steps at a time to the second floor of Building A. He headed right for the textbook section and grabbed Duncan Reid's book on normal and abnormal obstetrics.

"Hydramnios, 237-241." There it was, just above "Hydrocephalus, 242," in the index. The juxtaposition added

to his foreboding as David riffled back through the thick book. He began scanning ahead as soon as the page appeared with bold capitals halfway down, "HYDRAMNIOS," and his eyes, his heart, his whole being were riveted by the words, "commonly associated with developmental defects of the neural groove."

David slumped back into the library chair, inhaled sharply, and forced himself to read on, "as in spina bifida, anencephaly and hydrocephaly." He continued, dismissing the section about hydramnios occa-



sionally being present in otherwise normal pregnancies, while his mind raced about what to do next. He returned the book to the shelf and walked slowly down the marble stairs. He had to find Patrick Gage and learn what the X ray had revealed about his wife, about his child, about his family.

At the Lying-In, David had Dr. Gage paged. Soon a young man in a scrub suit and a long white coat came down the corridor. David tried to read his face but what had appeared somber in the distance warmed to a soft smile as Gage extended his hand in greeting. As David released the handshake he said, more as an assertion than a question, "The baby's no good, is it."

Gage nodded, now looking more grim. "Carolyn has an anencephalic fetus. We should have picked it up earlier. If she'd seen one of us every visit, we would have noticed the hydramnios four, five weeks ago."

He led David to a staff room off

the main corridor and motioned him into a chair. "How shall we handle this, David?" he asked.

"Why is he asking me?" thought David. His confusion cleared enough for him to say, "I'll tell Carolyn myself, but I need to know what comes next."

"The sooner she delivers, the better. If you can bring her back over this afternoon, she'll be admitted and induced tonight. She should be home in a couple of days."

David went back to the lab to retrieve his backpack and was relieved to find that Glen had gone to lunch.

He left a brief note explaining what was happening and that he would try to stop over the next morning to help wrap things up. They only had three more days in the lab before the rotations of the third year were to begin.

Bicycling over to Cambridge, David allowed himself to feel the deep sadness that was engulfing him. The tears blurred his vision and flowed onto the crossbar. He had no idea

what to say to Carolyn, how to break the news. He thought of the irony of a wasted summer, of a wasted move, of the need to change plans. He and Carolyn had just finished moving the previous weekend from their basement apartment on Beacon Hill to beautiful sunny second-floor quarters in the back of a large house off Brattle Street. They had arranged for free lodgings in return for light housework by Carolyn for two Harvard Medical School professors.

David's duties were limited to changing the storm windows, shoveling snow, and laying a fresh fire in the living room during the winter months—all quite compatible with the schedule of a third-year medical student and new father. Carolyn had already resigned her position as a public health nurse for the City of Boston and was planning to be at home with their baby full time.

David locked his bike and climbed the exterior flight of stairs to the deck off their apartment. He hadn't called.

He had just come and now he realized he wouldn't have to say anything. She would know as soon as she heard his footsteps. They sat together on the side of the bed embracing and sobbing while David explained what had to come next.

While Carolyn packed, David found Anna Lipton in the kitchen, having a smoke between psychoanalytic patients. He told her what had happened and that Carolyn wouldn't be able to prepare dinner the next night on the cook's day off. She brushed that aside and asked if there were anything she could do for Carolyn, if either of them had any family close by, and who was managing things at the Lying-In. A wave of shame and embarrassment briefly displaced his sorrow as David felt responsible for having brought this calamity into his new employer's home. He thanked her and retreated upstairs.

They drove in silence across the river, David placing his hand on Carolyn's thigh when not shifting gears in the traffic. She finally asked what he had neglected to find out

David felt more comfortable with the doctor's use of the word fetus than the alternatives of infant, child, son.

from Gage: "Will the baby be born alive?" He said he didn't know, he didn't think so. He hoped not.

Carolyn was heavily sedated and transferred by stretcher from her room to the delivery room. Gage had suggested that David wait in the resident's on-call room, which had the usual collection of old magazines, yesterday's newspaper and a few medical journals. David drank some bitter coffee and switched on the television. Other residents came and went, smearing peanut butter on saltines, pouring coffee, glancing at this stranger staring blankly at the television set.

When Gage entered the room,

David was alone. The delivery had gone smoothly and Carolyn was all right. He could see her soon on the ward. She would have to be on the post-partum floor and that would be difficult when the babies were brought around at feeding time. And one more thing: their child would probably not live more than a day or two and David would have to think about funeral arrangements.

The next morning David got to the Lying-In after the house staff and fourth-year students had finished their rounds. Carolyn was uncomfortable

Case Writing as Therapy

In the early stages of planning for the New Pathway Project at HMS, I was privileged to work closely with psychiatrist Robert Coles, among others, on the Patient-Doctor Curriculum Design Group. As we struggled to think of how we could engage the students of the Oliver Wendell Holmes Society in the deeply personal aspects of the lives of patients and their doctors, Coles repeatedly brought us back to the power of stories to illuminate the illness experience. The themes of the patient-doctor curriculum began to take form.

I took a stab at describing my first encounter with a patient. As a second-year student, I had failed to recognize a skin rash; I didn't know how to turn on the lights and was too preoccupied with my need to appear competent to ask the

patient if she knew where the switch was.

The passage of time had allowed me to appreciate the humor of the situation and to focus on the learning objectives of the case: the ethical dilemma of unskilled beginners "practicing" on patients, the importance of truth-telling, and the need to be self-aware and self-critical. At the same time, memories were stirring that I hadn't thought about, really thought about, for a long time.

As New Pathway planning moved on to the Life Cycle block, I began to think of the events surrounding the birth and death of my first child. When I told my wife, Cynthia, that I was thinking of writing a case for the New Pathway entitled "The Medical Student and the Frog Baby," her first response was to ask, "Haven't you worked

through that yet?"

Defensively, I said I wasn't planning to "work through" anything, but thought our experience was relevant.

When I gave a draft of the case to Cynthia, we began to remind each other of details almost forgotten, some never before discussed. We were transported back half a lifetime and realized how young we had been then, and how hidden to each other so many feelings had been in an effort to protect and soften the blow.

A colleague of mine suggested that someone videotape an interview with Cynthia so the students could have her perspective on the events described in the case. I thought that might be going too far, but agreed to discuss it with my wife.

Several weeks later, I borrowed

from the episiotomy and her breasts were beginning to fill and ache. She was subdued but putting on a brave front for David. She asked how he was and how their families were taking the news. Then, her eyes flashing with anger, Carolyn related how one of the fourth-year students, standing at the foot of her bed, had asked one of the other residents while Gage was examining the fundus of her uterus, "Do these babies ever live?"

She had felt Gage's hand tense on her abdomen as he wheeled and silenced the student with a harsh, "We'll discuss that later."

Because their child had been born alive and at term, they had to make arrangements for burial or cremation. They rejected the possibility of a funeral in any form, the first option mentioned by the woman in the admitting office when David had asked what they had to do about their deformed dying child.

They had just agreed to have the child cremated and his ashes spread in the garden of a local cemetery when Gage entered the ward and asked permission to talk with them.

Would they consider donating their child's adrenal glands for research purposes? David, who had been taking donations of tissue all summer, looked over at Carolyn. Their eyes met and agreement was reached without discussion. Gage provided more details. One of David's professors in the Biochemistry Department was studying the synthesis of corticosteroids and was particularly interested in the enlarged adrenal glands of anencephalic fetuses.

David felt more comfortable with Gage's use of the word fetus than the alternatives of infant, child, son. How

they had talked about names for this child. If a son, they had agreed to honor David's maternal grandfather and namesake, David Stuart Webster.

David was suddenly aware that Gage was waiting for him to say something, to ask another question, to agree. This time without turning to his wife, David blurted out, "How about using the whole body for research? Would that be any help? We've already decided to have him cremated anyway." Gage gently replied, "No, just the adrenals would be very helpful."

Later that evening, their baby died

She finally asked what he had neglected to find out: "Will the baby be born alive?" He said he didn't know, he didn't think so. He hoped not.

the videotape and took it home. Cynthia professed to have other things to do, but two of our children sat down with me to watch. As the interview unfolded, the three of us were more and more engrossed.

Among her insights was that she had felt angry at me for wanting to claim an equal share in the pain. "I was the one who had endured the pregnancy, the delivery, the postnatal suffering," she said. "How could he claim the experience? I realize that for years I have been enduring his shared ownership in silent anger."

She also observed, "We tried to deal with the event in medical terms, dispose of it as one would dispose of a tumor or other surgically removed tissue. It didn't work. Each of us has been haunted by the experience ever since. There

was the death of a person—the child we had nurtured in our minds, and I in my body—for nine long months. The death of that child needed to be acknowledged in some shared ritual so that it could be mourned fully."

At the time of the birth and death of our first child, I dealt with my sorrow by working hard and becoming absorbed in my work. I suffered under the misconception that it would be a sign of weakness and lack of courage to turn elsewhere for help. My job, I felt, was to comfort and support my wife and to find out if we were capable of producing a healthy child.

I was just beginning my third year of medical school and was planning a career in international health. Thomas Weller '40 had advised me to get at least two years

of clinical training before studying public health and going overseas. He thought either medicine or pediatrics would do; it was important that the clinical training be thorough and intense. I knew it would not be pediatrics, even though early in medical school I had been drawn to that specialty. I said nothing to Weller, or in fact to anyone on the faculty, about our recent loss.

To my knowledge, no one at the Lying-In, other than the resident who had delivered the child, made the connection that I was a medical student.

My first rotation of the third year was in medicine at Beth Israel Hospital. There, surrounded by elderly patients, I became absorbed in making arrangements for chromosome studies and reading about neural tube defects.

and David was asked to go back to the admitting office. "We need a name for the death certificate," said the clerk on duty, "It's required unless it's a stillbirth."

David sat down and wrote in the necessary information, first Carolyn's full name, then his, then David Stuart Webster Cantrell. "I'll always remember him, even though I never saw him," thought David.

*They gazed at the prints of their
genes in wonder, little black smudges
like so many floppy-limbed marionettes
in all shapes and sizes.*

The next day David drove Carolyn home. It was now Friday of orientation week, and he had managed to register for the third year but never had gotten back to the lab to help Glen finish up. Glen and their faculty research advisor had suggested that they meet in a few weeks when things had settled down. Carolyn was already talking about going back to school for the last semester of her bachelor's degree, perhaps even do some special duty nursing to help with the finances. David was relieved that his first rotation of the third year would be at Beth Israel Hospital, in medicine, and that he wouldn't

have to return to the Lying-In until February.

But hardly two months had passed when David found himself walking into the Lying-In to see Richard Hager, a fertility expert whose name David had found while doing some reading about anencephaly. David wanted to find out what was known about the inheritance of this defect which one journal article had described as being more common in people with Scottish ancestry. Hager explained that there did appear to be

some association between chromosomal abnormalities in one parent and developmental defects of the central nervous system, but that the great majority of these events were still unexplained and seemed to happen by chance. Nonetheless, it would be appropriate for David and Carolyn to have chromosome studies done. He suggested a geneticist at Children's Hospital and encouraged David to come back if he had more questions.

It took another month for David to arrange an appointment with the

Three months after losing the child, I was obliged to start pediatrics at Children's Hospital.

In 1962, the third-year rotations did not include any direct patient responsibilities and we had had no night or weekend call—which may have added to the difficulty I felt at engaging myself fully in the pediatric rotation. Hard as I tried, I found the sick toddlers unbearably painful.

Each suffering child became my suffering child, and I retreated each day from the hospital feeling beaten and incompetent. I was also torn with guilt at what I perceived as unworthy self-pity. I contrasted my feelings with the courage and dignity I observed in the parents of some of the sick children I examined.

Ten months later, I talked with the dean of students about intern-

ships and my dean's letter. He shuffled the papers of my transcript and clerkship reports, and told me he thought he could write a strong letter for me.

"There's just one thing that doesn't fit," he said. "Your pediatric rotation last winter: it sounds like they mixed you up with someone else: 'Student seems detached, uninvolved, distant.' What do you make of that?"

I knew clearly what had been going on, but felt unable to explain and instead mumbled something about it being a difficult rotation for me.

When I matched with my first choice for a straight medical internship at Massachusetts General Hospital, the irony did not escape me that it was the only program I had applied to which required one month of pediatrics during

internship.

Almost two years had passed since the death of our first child and one year since Cynthia's second pregnancy ended in a spontaneous abortion at 10 weeks. Now she was pregnant again and we were hoping for success. Most of the children at the Burnham were older, and I was managing better than I had as a student at Children's until a beautiful nine-year-old girl died of Rocky Mountain Spotted Fever. The resident and I had been up with her most of the night, trying desperately to sustain her vital signs in the presence of liver failure and bleeding.

Her anguished parents, only a few years older than I, had been up with us, willing her to live. I remember thinking that what I had experienced in losing a child at birth was nothing compared to

geneticist. By the time he and Carolyn went to have blood drawn for leukocyte cultures and ideograms, David found himself almost excited by the quest. He had persuaded himself that if their chromosomal studies were normal, their child had most likely been the product of a random event, maybe some virus during Carolyn's first trimester. The geneticist said nothing to dissuade David from this point of view.

The answer arrived in the mail: a short note from the geneticist indicating that both karyotypes were normal pattern and the photographs themselves! Carolyn and David were thrilled to think it might be safe to have another baby, and they gazed at the prints of their genes in wonder, little black smudges like so many floppy-limbed marionettes in all shapes and sizes but all having two arms and two legs!

In December, David started his six-week pediatric rotation at Children's. It was upsetting to work with the sick children, and he was imme-

diately aware of the difference between the way he had plunged right in at the Beth Israel and how he was holding himself back on the toddler ward. He rotated with two classmates he didn't know well. His instructor was nice enough, but seemed to spend all of his time talking about pathophysiology while David was preoccupied by the suffering of these children. As far as David was concerned, the six weeks couldn't end soon enough, even if the end meant going over to the Lying-In for the six weeks of ob-gyn.

On the fourth day of the ob-gyn rotation, the 12 third-year students were scheduled for their first X ray teaching conference. David settled into a chair in the second row next to one of his good friends. The radiologist put up films from the teaching file and pointed out features of the normal pelvis and birth canal. David thought of the events surrounding Carolyn's hospital stay and then of Carolyn herself.

The radiologist began to show films of normal pregnancies, of fetuses at different stages of develop-

ment, and, finally, of normal heads engaged in the birth canal itself. David half looked, half listened, and thought back to the recent Christmas break at his mother-in-law's home in Connecticut. A classmate from the West and his wife and infant daughter had spent the holidays with them, and David had been deeply moved by Carolyn's ease and obvious pleasure in helping care for the infant.

The radiologist began to display abnormal X rays. First, the android pelvis, then examples of cephalopelvic disproportion, breech presentations, transverse lies, anencephaly. Anencephaly. David had seen the plates in the books and articles he had read in September, but here it was life-size, looming at him from the view box.

Then he noticed the unit number and date, 9/6/62. This was Carolyn's film, his son upside down, light and dark shadows. The radiologist's pointer outlined the characteristic features, the almost total absence of the skull, the shape that the radiologist said had given rise to the name "frog baby." □

what these parents were suffering, and the old guilt and recrimination began again.

A month later, we were devastated when Cynthia's third pregnancy ended in a spontaneous abortion while I was working every other night on the Bulfinch. We slowly resigned ourselves to the awareness that we were not meant to have children. Later in the year, we initiated adoption proceedings with an agency in Cambridge and threw ourselves into our work.

I felt some of the pressure lifting and, despite the intensity of my schedule, was actually enjoying internship. Cynthia had left nursing and was teaching at a private elementary school in Cambridge. We were feeling somewhat more reconciled to our fate when Cynthia again became pregnant. We were on tender hooks until the first tri-

mester passed, and only then slowly allowed our hopes to build.

Our son Job was born on October 30, 1965, while I was on the roof of the Boston Lying-In with Duncan Reid and one of the residents, trying to see the comet Ikeyi-Seki, which was supposed to be low in the southern sky. When the big event finally came, in that era when fathers were not allowed in the labor room, much less in the delivery room, I dealt with the crescendo of anxiety over whether we were about to have a normal child or another monster by going to look for a comet with the professor of obstetrics!

In looking back at these events, which occurred during my evolution as a young physician, I am struck by how unable I was to ask for help. In part I was bound by the stiff-upper-lip philosophy of life

engendered by my family and my culture. In part I was reflecting the arrogance of our profession. We are in control; we can handle things; we know what is best.

Independence and self-reliance were inextricably caught up with distorted notions that detachment and objectivity were an essential part of clinical competence. Gradually, I have learned the wisdom of Erik Erikson's admonition to use "disciplined subjectivity" with our patients, to explore and examine the particularities of our own lives so we might better appreciate those of our patients. For me, this notion has meant accepting my own vulnerability and need for help. I hope it has made me more tolerant and accepting of these characteristics in my patients. □

Empathy Lost

Chronic illness sets a psychiatrist in search of compassion and dignity

by Judith Alexander Brice

Well, Judy, you've got what you've been working on." With that sarcastic statement, my gastroenterologist walked out of the room. I was stunned. To be sure, I had worried. But had my worries "worked on" the illness or on me?

My doctor knew of my fears of ulcerative colitis from our discussions of my family history. My mother had needed a colectomy after becoming critically ill with ulcerative colitis, my brother had struggled with two severe bouts of Crohn's disease, and symptoms of irritable bowel had plagued me from childhood.

When my doctor returned a few minutes later to prescribe Azulfidine, he lectured me out of my tears, leaving me to struggle alone through worries of smelliness, uncontrollable diarrhea, and possible body mutilation. His hostile, critical tone conveyed to me that my illness was somehow my own doing. Guilty, anxious, only marginally aware of my fury, I returned home. If it was my own doing, how could I undo it?

One of the unspoken tenets of my Harvard medical training had been that there *is* an answer out there. If

you only knew more, if you could put the facts together in a new way, if you were a little smarter, you could find it. Over the next eight years, my search for an answer to my disease would take center stage. Kindled that day by a doctor just a little too busy to concern himself with the impact of a few words upon a single patient, the search was to be fueled by my personal make-up, my medical training, and all the uncertainties of etiology inherent in a "psychosomatic" disease.

I kept feeling that I might find some connection that would enable me to get over my colitis. Perhaps there was a dietary cause; perhaps anxiety played a part. Usually, just as I gave up, a friend or a colleague said, "I have a friend who drank chamomile tea every day and hasn't had a symptom of colitis" or "I know someone who gave up roughage and . . ." The list was endless. It was hard to stare down that last glimmer of hope and say, "No, I've tried enough." Consequently, psychoanalysis, special diets, and quack blood tests supplemented a routine complement of Azulfidine and steroids (on which I became dependent).

The stigma of ulcerative colitis as

a psychosomatic disease (despite the renunciation of that etiology today by most gastroenterologists), was ever present. Many friends seemed to feel they could be helpful by pointing out what they considered to be likely life stressors. For me, their interpretations were corrosive indictments. I felt increasingly different and estranged.

I also felt embarrassed to tell my friends about my "unmentionable" habits. Bowel movements, diarrhea, flatulence, and body odors are considered personal and private in our society. When I did tell my friends about my symptoms, I sensed their discomfort and criticism. I was ashamed and lonely. As I got sicker, I felt increasingly dirty, smelly, and unfeminine. I was desperate for reassurance.

My second gastroenterologist was calm and matter of fact. Unlike my friends, he was willing to hear about my symptoms without embarrassment. This attitude and his respect for my thoughts were invaluable in mitigating my insecurities and fears. Psychoanalysis was also beneficial. Careful self-scrutiny helped me understand how unresolved problems impeded my optimal adjustment to my illness, though I could never pinpoint specific emotional factors as the cause of aggravated symptoms.

In January 1982, after seven years of moderately good health, I became suddenly worse—triggered by a severe gastroenteritis. Overnight my life became a roller coaster. One day I was up, both physically and psychologically; the next day I was down. My colitis and my responsiveness to steroids no longer made even a modicum of sense. Both the course of my flare-ups and the intensity of my symptoms were unpredictable. I might have four and a half good days and then suddenly find myself running to the bathroom six times at the end of the fifth.

My inability to be dependable, especially in my profession, was dev-

astating to me. I was reluctant to let other professionals know of my illness because of its psychosomatic stigma. Yet I had no choice but to cancel out unpredictably, often at the last minute.

The sicker I became, the more unreliable I got and the angrier others grew as their lives, plans, and work were disrupted. Like most physicians, I was proud of my work and derived self-esteem from my commitment to others. Suddenly, I had to renege on my family, friends, patients, and colleagues. Even when I did not, I was often preoccupied by my symp-



toms or concerned about whether I would get through the day without an embarrassing, urgent interruption.

I began to hate my body and felt betrayed. My most trusted friend had transformed itself into my biggest adversary.

My self-esteem, so closely linked to my ability to function reliably, eroded further.

That winter I was twice admitted to the hospital in an effort to control the ravages of my illness. If anything, these admissions were countertherapeutic. The insensitivity of some medical personnel greatly exacerbated my struggle to maintain self-respect. Once, between X rays for an upper GI series, I explained to a technician that I was too weak to walk to the bathroom, and that I would need ready access to one. "Well make up your mind if you need to go or not," she grumped back. Shortly thereafter she left me unattended in a hallway, hooked up to an IV with no bathroom access at all.

Even now, I want to scream back, "If I could make up my mind, I wouldn't be here at all." But I needed help and I was helpless, so I tried to comply.

As a doctor I functioned in a profession of strength, intellectual activity, control, and independence. These qualities did not mesh easily with those of a passive, compliant patient, and, during hospitalizations, I found it difficult to switch gears.

One minute I was the psychiatric consultant, heading up case conferences, seeing private patients, and supervising residents. In my personal

life, I ran a household and related to the needs of my husband and two-year-old son. The next moment I was in the hospital, where social, professional, and personal boundaries were suddenly subject to thoughtless and repeated violation. Doctors walked into the bathroom to examine me on the commode; maintenance staff greeted me when I stepped out of the shower; nurses entered my room at night, clanging ice pitch-

ers and laying out new linen.

Finally discharged on high-dose steroids, I was grateful to be home and at least in charge of such matters as who saw me naked and who entered my living space. I was still terrified, however, that my body remained out of control.

Two months later, still on 60 milligrams of Prednisone, I was asymptomatic but cushingoid. My gastroenterologist tentatively suggested an ileostomy and I balked. I could not imagine a satisfying life so disfigured. We agreed to seek a second opinion.

The doctor I found had an excellent reputation. Nevertheless, he conducted a cursory history with a sharp tongue, and I was ill-at-ease throughout the sigmoidoscopy and physical exam. Because of this experience, I unfortunately dismissed his recommendation for an ileostomy, which was based on his concern about long-term steroid use.

My conviction that there must be an answer if only I were smart enough

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to find it was goaded on by my prejudice in favor of big teaching hospitals.

I decided to be evaluated by an expert in New York City and possibly to have the Kock procedure, a non-disfiguring operation resulting in an internal ileostomy.

After six days in a New York hospital, I had seen the expert only three times. Suddenly he whisked into my room. "It would be madness," he declared to my husband and me, "for you to get a colectomy." Disregarding my history of steroid dependence and the fact that he'd seen me only when I was taking 60 milligrams of Prednisone daily, he presented 6-mercaptopurine (6-mp) as the answer to my dilemma. He dismissed my concerns about the side-effects of 6-mp and of excessive use of steroids for several months more while the new drug took effect. The risks, he stressed, were minimal.

My husband was outraged: how could this doctor call it "madness" when two doctors in Pittsburgh had recommended an ileostomy? Did he mean to imply that his own assessment was far superior to that of my Pittsburgh physician who had followed my progress for seven years? I wonder now, if it was too threatening for him to admit that a fellow physician of less academic stature might know as much or more than he about my condition.

But I was looking for magic and wanted to believe I'd found it. Consequently, for several months I took the 6-mp, gradually trying to lower the steroid dose. My symptoms did improve somewhat, but I was worried to the point of intermittent panic about agranulocytosis.

I was so preoccupied by a fall in my white blood count and hematocrit that I did not pay much attention to a mild pain in my hips. "Arthritis," I told myself, and the pain seemed to go away. Vaguely, I knew something could go wrong with my hips. My brusque consultant had mentioned avascular necrosis (AVN).

As a doctor living with a chronic disease, I struggled to use my medical knowledge to master the disease, and yet to let go of excessive worry and concern. I felt constant tension in working this out. When a hip X ray proved negative, I convinced myself that the problem was minor, and began to relax. I had sorted out my hip pain and placed it on the back burner, out-of-sight and mostly out-of-mind. I desperately wanted to be well.

When I finally telephoned an orthopedic surgeon, I was unprepared for the degree of alarm on the other end of the line. Within 12 hours I had had a bone scan, and that night, over the phone, I learned the results. "My dear, your hips are being supported by dead bone. At any moment they might collapse. From now on, you must act like you are paralyzed."

When my husband and I went to the hospital, we had to discuss my future in the cafeteria, as the hospital had no rooms set aside for doctor-patient conferences. My doctor told me that the facts were simple: my femoral heads were dangerously close to collapse. The AVN, probably caused by high-dose steroids, could not be corrected until I had had a colectomy and was off steroids. Even then, the most successful surgery—a live bone graft—was only 40 percent reli-

able and would require extensive time in the hospital and rehabilitation. If the surgery failed, I would need hip replacements, a solution which was itself fraught with problems. I hated crying in the cafeteria, but there was nowhere else to go.

Within 26 hours, my focus had shifted. I had traded in one chronic, debilitating disease for two. I not only needed an ileostomy, but I would be in a wheelchair for a long time and might never walk normally again. Time, magic, and choice had vanished. I was scheduled for surgery three days hence.

The colectomy, in November 1982, was awful; my post-op course and the pain, both atypical, were far worse. Each time the nasogastric tube was pulled, I became nauseated, developed back pain, and vomited. The NG tube was then reinserted, left in for a couple of days, and then, once again, the picture repeated itself. My pain and my course were atypical, and because I couldn't walk I was also more helpless than most post-op patients.

Perhaps for these reasons, or because I was a doctor who wanted to offer ideas about my own care, the staff began to dismiss and overlook my needs. After my urinary catheter was removed, for example, I developed an atonic bladder and was unable to void for over 14 hours. When I begged the nurses to call the doctor for a straight cath order, they bickered with me for four hours. Maybe I didn't really have to void; maybe I just felt like I had to. The nurses finally got an order, and, to their embarrassment, my bladder was indeed extremely full.

Over the next week terror eclipsed my frustration, as the staff's neglect evolved into aggressive abuse. My continued illness seemed to be a thorn in everybody's side. Each nurse offered a different explanation for why I did not get better on schedule. It was clear to them that I did not want to get better. Some of the nurses tried to cajole; most became condescending, only thinly disguising their disgust. One told me I just needed to learn to live with the pain. Fewer and fewer people believed I had a real problem, or "real" pain.

When a UGI series was read as negative, my doctor was convinced, despite my complaints of anorexia and back pain, that I was on the road to recovery and should not need my

NG tube or further analgesics. In front of the nurses, he lectured me on the hazards of excessive opiate use for pain control.

A few hours after that visit, my pain gradually increased. My doctor had all but forbidden me to call him directly. My private duty nurse asked the charge nurse to call the doctor, but, for over two hours, the charge nurse put her off. In severe pain, I began to moan. I knew I was obstructed. I rang my call bell, but no one answered. Finally, my husband pleaded with the charge nurse, in the hall, to help me. She ignored him. The pain became excruciating.

When my husband went out to plead again, the charge nurse barreled into my room. "Dr. Brice," she said, "I want you to quit moaning and quit manipulating. I have another patient moaning in the next room, and if you think you are going to get me to give you morphine or call your doctor, you are wrong."

After a half hour more of my husband's pleading, the charge nurse finally returned only to exclaim, "Oh shit!" when she observed the 1000 ccs of vomitus splattered on the floor. Realizing her mistake, she scurried about, cleaned up the vomit, and called the doctor, but did not speak to me.

The terror of that night is as vivid as if it happened yesterday. The memory continues to haunt me. I was desperately ill and helpless, and in that bleak moment my most important helper had become my harshest accuser.

Two days later, and a month after my initial surgery, a laparotomy revealed massive intestinal adhesions. The surgery that was to take one hour ("At the most," my doctor had predicted) extended into four and a half hours. With no word of my condition, or the reason for delay, my husband and mother could only imagine the worst—cardiac arrest. We saw how empathy for the families of patients was clearly a low priority for some doctors.

When I was wheeled into the recovery room after that operation, I woke up extremely cold and in severe pain. A nurse took my pulse. When I politely asked her for another blanket, she barked, "I just brought you one; I'm not going to bring you another," and disappeared. When she returned to check my pulse again, I pleaded with her to be nice. Angrily, she picked up a sheet, threw it at me, and again walked away.

After three days in the ICU, I was marginally stabilized and returned to a regular room. My condition worsened, however. I developed gastritis, and bled through my nasogastric tube. I was hooked up to an IV line, a hyperalimentation line, a Jackson Pratt tube, and I had a non-functional ileostomy bag strapped to my waist. My surgeon came in, watched the blood drain, and lectured me: "The problem with you, Judy, is that you're too anxious."

I wondered how he might feel if he were in my place, and I wondered why, knowing I was anxious, and telling me that my hematocrit was stable, he ordered two units of blood one night without a word to me. Perhaps he was frightened because my illness reminded him of his own vulnerability to disease.

The more my condition deteriorated, the more my world diverged from the world that had been mine before the illness. Every day was a struggle to accommodate one to the other, to focus them both in a single image.

My world was now that of tubes, drains, and repeated stabs, of punctures, pushes, and shoves. The "real" world—that of my husband and son—kept vanishing. I clung to the life in others and consciously forced myself to inch outward. Word by word, I invited the staff, my family, my friends to talk about their lives, their families, their battles with the snow. They were my link with life.

When my surgeon came to see me, he would not look at me. His gaze wandered toward the window or

the television. I yearned for him to sit for a minute, hold my hand, give me reassurance. He never did. He checked the NG tube and noted it was draining copious amounts of fluid. He checked my ileostomy bag and noted the absence of any output. We both knew that these were not good signs. The sicker I became, the colder and more irritable he became, and the more death loomed before us.

My husband and I could see that my surgeon was taking my decline as his own personal failure. When, with the naivete of a layman, my husband asked him why I wasn't getting better, my surgeon twice protested that he was sure it wasn't *his* fault. Thinking he might take offense, my husband and I were frightened of being forthright in requesting a second opinion. At that point my care was too critical. My life hung too precariously in his hands.

After several grim days, my surgeon pulled out the nasogastric tube one last time. He told me then that if this effort failed, he foresaw several months of hyperalimentation. This time I responded well, and, in delighted amazement, I returned home only five days after the tube was pulled.

I was coming back to a house I had known as an independent, albeit sick, woman, wife, and mother. Now I was disfigured, dependent, and crippled. My husband and I tried to hold on to the miracle of my survival to give us confidence in approaching the next hurdles.

I began to search for the next answers: how to get over the problem with my hips, and how to get around without them. When I decided to seek a second opinion about my AVN, my

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first orthopedist was furious.

The problem was confounded when additional opinions differed substantially from the first. Still believing in a magic "right" answer, and still holding Harvard in highest esteem, I consulted three physicians there. One physician encouraged me to travel to Boston, emphasizing how difficult it was to diagnose avascular necrosis over the phone; the second recommended a core decompression; and yet another Harvard specialist suggested that I wait until the hips fracture and then replace them.

Each was convincing. In the end, I placed my bet with the only recommendation made by more than one of the six physicians I consulted: a bilateral core decompression. Within a month and a half of leaving one hospital, I returned to another. Fortunately, the surgery went as planned and the medical care was consistently good.

A few days later, I returned home, still with an uncertain prognosis and still strongly admonished to get off my hips if I felt any pain. But this advice was difficult to follow. Using crutches, I could stand for only three minutes without pain. My choice was to remain immobile or use a wheelchair.

As the weeks turned into months, I remained far from independent. I had no notion of how infinitely time consuming even the simplest chores could be. When the UPS man refused to climb back up five stairs to carry a package into the house for me, I was furious. When an obese man took the only parking space designated for the handicapped, and then justified doing

so in a taunting way ("Well, I'm handicapped too; I weigh too much"), I was enraged. These people, and others I needed so desperately, did not know how important a kind word or gesture could have been.

My progress could hardly be called swift. One year after my return home, I was able to take only eight normal steps without pain. Once again, I got several new opinions, and, once again, I was unprepared for what I heard.

One famous surgeon refused to review my bone scans and told me that he could find nothing wrong with my hips. Apparently incapable of respecting my own observations or those of other doctors, two of the orthopedic surgeons I consulted diagnosed mild back strain! They seemed oblivious to the facts that six other doctors had diagnosed AVN, that I had undergone a life-threatening operation due to that diagnosis, and that I had spent the last year of my life in a wheelchair. They were apparently more interested in validating their favorite theory about AVN than in treating my disease.

Using my medical knowledge to assess my own symptoms and to integrate the opinions I had heard, I judged the diagnosis of back strain absurd. I elected to continue my slow, conservative course.

Two and a half years after my surgery for AVN, I finally got to the tennis courts again. Now, a year after my first tennis game, a personal smile, a gesture of help, or an expression of empathy still moves me to tears. As I look back, I wish some of my doctors and nurses could have opened themselves to the same kind of empathy

I've found in neighbors, grocers, flight attendants, and dog trainers.

As a physician, I am aware of how draining and threatening empathy for helpless, injured people can be. I know how hard it is to hold on to compassion when all of one's invested power and energy seems helpless against the tide of fate. Yet at times it seemed that some of my doctors and nurses had retreated to narcissistic, self-centered stances, categorically dismissing my own impressions and those of other doctors.

Their need for power and control seemed to impede their ability to empathize with my state of enforced passivity. As a patient, I felt more alone, more helpless, more terrified, and more enraged than I now believe I had to be.

My experience has left me with tremendously conflicted feelings about my colleagues and my profession. For those who could not imagine what it would be like to be in my situation, I feel not only a puzzled bitterness, but, ironically, a sense of shame. For those who treated me with kindness and understanding, I feel inexpressible gratitude. I will always remember the devotion of one physician friend and a few superior nurses whose words of encouragement were vital to my recovery.

I now realize that before my illness there were gaps in my empathy for the chronically ill and handicapped. Unfortunately, it took my own experience to realize how even the most "routine" task can seem insurmountable to a handicapped person. When one is confined to a wheelchair, a spilled glass of milk, a package left on the front porch in the snow, or a flat tire become major undertakings.

Like Blanche in Tennessee Williams' *A Streetcar Named Desire*, the vulnerable "have always depended upon the kindness of strangers." Now I know what that kindness can mean. □

Judith Alexander Brice '71 is clinical instructor in psychiatry at University of Pittsburgh, has a private practice in psychiatry, and is medical director of a partial psychiatric hospital program for children and adolescents at St. Francis General Hospital in Pittsburgh. She has recently consulted at Harmorville Rehabilitation Center and at Western Pennsylvania School of the Deaf. A version of this piece will appear in a book on doctors as patients edited by Howard Spiro '47.

From Hypochondriasis to Denial

*The metamorphosis of a medical student
into Ironman of the Wards*

by Peter Rintels

I suppose some literary cognoscente is going to try to tell me that this comic-book stuff is strictly for lightweights. But when the excitement of one more chest pain or another abnormal secretion wears thin, I have been known to find pleasant refuge at the newsstand—where my eye wanders across the dry headlines in the *Times* over to the comic-book racks.

It is a neat progression, really, from the local news to the national, the international, and right up to the intergalactic, where the hounds at Marvel and DC Comics dish out the latest scoops on the likes of Star Boy, the Chameleon, and Nura the Dream Girl.

In fact, I am ready to make my own contribution: a character called “Ironman of the Wards.” His mystical power is the ability to repel all illness, or convince everyone else he has. This man does not miss a day of work for anything short of a coma.

As I suspect most *Bulletin* readers are aware, hypochondriacs are rare among physicians. That medical students, however, are prone to active

imaginings is an observation sufficiently commonplace to be enshrined in serious medical texts. And what a relief that is. In 1965, a survey of 33 southern California medical students elicited 79 percent acknowledgement of “medical students’ disease,” or MSD (Woods *et al*, “Medical Students’ Disease: Hypochondriasis in Medical Education,” *Journal of Medical Education*, 1966; 41: 785-790).

This condition is defined as “the development of either symptoms of, or hypochondriacal anxiety about, the disease being studied by the student.”

Thus, on the eve of the age of Timothy Leary and Carlos Castaneda, there was confirmation that a medical education is one of the most potent non-chemical hallucinogens known to mankind, capable of creating among students the certainty that they are dying of improbable illnesses.

In all fairness, medical students are not true hypochondriacs. While the real item is not the least assured at being told he has nothing, the MSD sufferer knows that his/her life has just been saved.

Another contributor to the litera-

ture on the subject has assigned the term "nosophobia" to the phenomenon (Hunter *et al*, "Nosophobia and Hypochondriasis in Medical Students," *Journal of Nervous and Mental Diseases*, 1964; 139: 147-52).

A bit daunting, perhaps, to the non-Greek-speaking psychiatric amateur, but one gets the picture. Seventy-nine percent of medical students are not full-blown neurotics destined to haunt physicians with major league psychiatric illnesses. They have merely a "monosymptomatic adaptational concern in [an] essentially healthy personality." What a relief.

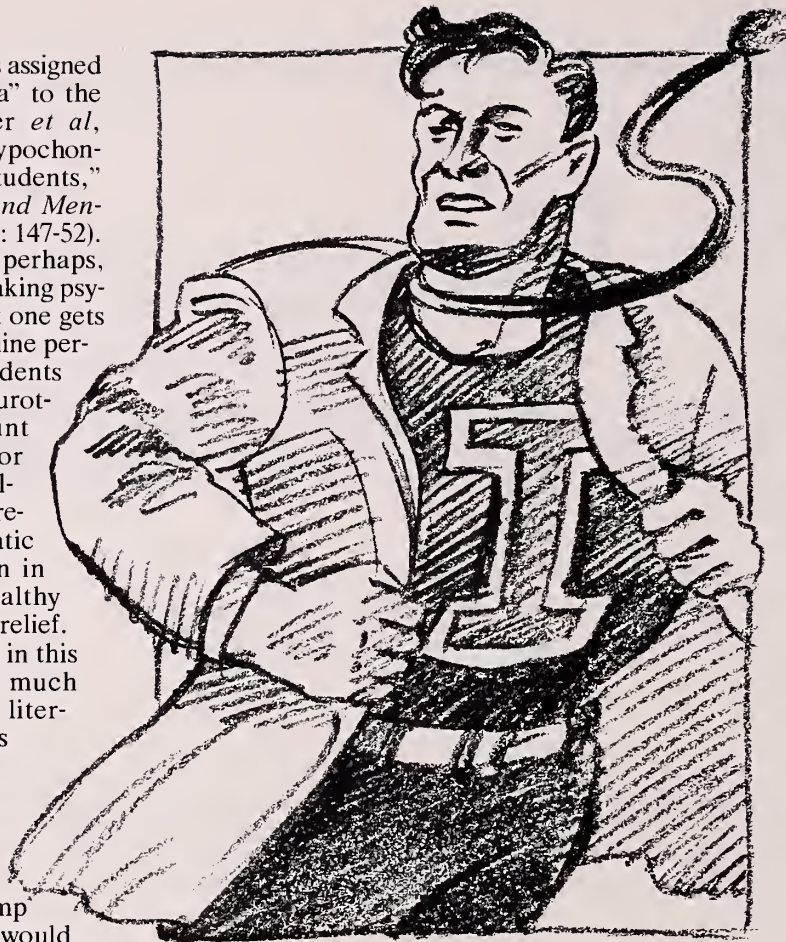
My own expertise in this area derives not so much from knowing the literature on the topic as from *being* that literature. It was not so long ago that I was grovelling to the student health service with a certain lump in my neck (a node I would now call "non-pathologic"), convinced of its fatal implications.

I played the game by the rules as best as I knew them at the time. I let the thing go a month, and then another month. But it just sat there whispering, "This is your lymphoma calling; I'm still here."

I finally approached a resident and meekly had him "uh, tell me what you think." After he failed to laugh me off the ward, I went to have the thing looked at "for real."

I imagined that once I was informed I had only two years to live, I would go darting around the globe Ben Gazzara-like, touring exotic capitals with fast cars, expensive booze, and beautiful women. I'm no fool. No neurosis, and certainly no lousy "adaptational concern," is going to rob me of a good time. Luckily, before I made the down payment on the Ferrari, I was told that yes, there was a node there, and no, it was nothing. What a boring life I've lead as a result.

A colleague of mine, struggling to keep her sanity at about the same time, knew what her real problem was from the start. "Look," she told the doctor, "I want you to know that I'm a medical student. I've noticed some bleeding from my gums when I brush my teeth and I think I have leukemia."



This problem netted less sympathy than it deserved. "He laughed," she reported.

The current generation of medical students seems determined to keep this proud tradition alive. The local twist seems to be originality. What strange malady haunted the student who complained of, among other things, increased saliva on the right side of the mouth? Or the one who, over the course of an hour, found that "before I couldn't feel my PMI; now I can feel it!"?

Having seen medical student's disease from both sides, I wonder now why no one has yet gotten around to installing a trap door activated by the words, "I am a medical student and I think I've got . . ."

What goes on inside the doors of the nearest medical school may hold a key to the cause of these deliriums among medical students. Inside lurks tale after tale of microscopic monsters, molecular perturbations with hopeless consequence, and neoplastic blobs that would give Boris Karloff and a gaggle of his writers the shivers.

Whatever the imagination does to protect itself from vampires, swamp things, and demons does not seem to work in the face of MSD. Scattering Rice Krispies on the bedroom floor

for instance, would do little to alert you to the treat of a diffuse histiocytic lymphoma.

If everything in medicine is not quite this sinister, that is not the message given to students. Medical school faculties are not famous, on the whole, for world experts on aches that go away, coughs that are nothing, or lumps normally found on the human body. High-powered academics do not globe-trot to dispense their internationally renowned wisdom on the sniffles. Role models are not overheard saying, "Congratulations! Your review of stupid headaches that go away when you get new glasses was an *impressive* piece of work. Six hundred references! I suppose you're a cinch to make a professor now."

No, faculties are full of scenarists, slides and case reports in hand, ready to outline how some misplaced proton can reduce the finely tuned human organism to a wreck. Every possible protoplasmic disaster is described in fine detail. Students easily imagine them-

selves as a mound of whipping cream ready to be decimated by the next atmospheric disturbance.

Suddenly, Greek words that would have knotted the tongue of Homer creep into the mind. Could this little headache be the old craniopharyngioma kicking up again? Or the chromophobe adenoma? How about them sniffles? A touch of Wegner's granulomatosis perhaps? Now that you know what's out there, are you still sure you shouldn't sleep with the lights on at night?

But the job is not finished yet. Skulking about that bundle of nerves is still a glint of sanity. Not to worry. Nothing that a little time at a university hospital can't polish off. Here, stupid coughs, rashes, fevers, and aches have all been screened and turned away at the door. Out of all the crazy coughs that doctors see, the one that heralds some exotic monstrosity is the one you'll find here.

My personal favorite is Histiocytosis X. No other disease sounds more like it originated in another galaxy. (Say "Histiocytosis X" slowly a few times, and see if you still think it's truly a disease of terrestrials.) Only the most rock solid mind will make it through these wards without blowing a gasket somewhere along the line.

Completeness compels mention of the findings of Dr.s Woods *et al* who, after comparing the personality inventory responses of their group with MSD (80 percent, remember?) and those without, concluded that "while MSD is not an impediment to learning . . . it is often a signal of general emotional distress and conflict." And that "MSD as a cry for help has been all too often obscured by the jocularity and humor that has defensively hidden its significance in the medical school subculture."

The ability of the medical diploma to eliminate all vestiges of MSD couldn't be more impressive if it were handed out by the Wizard of Oz himself. This therapy is so effective, in fact, that it's a wonder it hasn't been tried out on other illnesses as well. (Then again, maybe it has.)

What modification of humors turns graduating medical students into iron men and women? Like all sturdy armor, ours has its origins in fear. For interns, new demons replace the old. I count three.

Fear of looking like a fool.

The prevailing, if unstated, wisdom holds that, while saving lives may be top priority, saving face cuts a close second. It is one thing for a student to mistake an odd ache for a deadly disease, but quite another for an intern to do so while struggling to establish professional standing.

While Joe Average Patient may be comforted by a physician who says that his viral syndrome will get better and is nothing to worry about, a physician told the same thing will not be reassured. The physician knows that by the time he has consulted a colleague, the problem has gotten serious enough to get a second opinion (the first being his own). The news that he has nothing serious may make him feel silly and compel him to fumble for an explanation of why he didn't know that himself.

"Well," he may say, hoping to gain the upper hand by citing an illness about which his colleague could not possibly have heard, "I understand there's a rash of von Eponym's disease going around. Of course, I don't see much of that in my practice, so I thought I better get it checked out."

"No, no," his colleague may reply, trying to retake the high ground, "I don't think the fever is, er, quite high enough for that, but we'll have to keep an eye on things to be sure." And then they will part, trying to

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pretend the whole conversation never occurred.

Opting not to amuse her colleagues with a chief complaint of "feel tired and have fullness of the head," a friend of mine with a thyroid condition used the occasion of a patient dying in the emergency room to send some blood tests off under his name. When the TSH returned higher than 150, she felt she had solid evidence that either her pituitary was involved in a takeover bid or a substantive illness had turned up. By the time she actually sought medical attention, she had enough periorbital edema "to fill a bucket."

Fear of making enemies.

I suppose it is only natural that residents who admit a significant number of their patients at hours when they are so tired they can barely keep their eyes uncrossed will have a high threshold for what they will accept as incapacitating—especially if it involves expanding their or someone else's workload. Then there is the problem of watching a carefully crafted call schedule dissolve into rubble when the right person is not available at the appointed hour. Should you be the unlucky person responsible for this calamity, it may just happen that your chief resident will not love you anymore.

As a junior resident, I had the unhappy experience of having a virus start sojourning in my GI tract on the eve of a call night in the ICU. There was no difficulty in getting covered for the day. I lay in bed nursing the monster until I got a couple of anxious phone calls from the chief resident as 4:00 approached. (This was in the days before we adopted a sick call schedule, when the only back-up plan was to call around and see who was not doing anything that night.)

In the interest of keeping the peace, I adopted the posture that if I could take clear liquids and keep the temperature below 101, I would work, which I did. Thus was born the informal rule, "Tylenol and no call," when

the temp hits 101.

Essentially, it's a variation on the fried-egg rule, which states that if it takes longer than 10 minutes to fry an egg on your forehead, you can work. The literature is silent on the value of this test.

We now have in place at my hospital a back-up schedule, long overdue, which has effectively removed the trauma of having a sick resident. It has also allowed us to remove some of the padding from the chief resident's office, though not all—we still have to decide who works on Christmas. I am inclined to take seriously the complaints of residents who feel too ill to work. Chances are, we should have a DRG for this category.

Fear of pain.

I suppose somebody, somewhere, has been reassured by the words: "I've done lots of these before, and they only hurt a little; really; just a bee sting." When we find him, maybe we should put him in a nice cage at the Natural History Museum where disbelieving crowds can pass by to see just what kind of creature he is. It certainly won't be me.

What it is that allows perfectly grown men and women to talk to other perfectly grown men and women as if they were two-year-olds who could be convinced that the shiny needle heading toward their pain receptors were really a Q-tip, eludes me.

If the day comes when someone should be pointing the business end of a jamshiti or LP needle toward me, I've already memorized my lines: "Can the baby talk? Spare no lidocaine and let's get on with it."

My sentiments may be shared by the larger non-physician population. What I know, and they don't, is which symptoms are most likely to be shish-kababed by the eager resident. This is information which, experience suggests, we physicians should keep to ourselves. □

Peter Rintels '83 is chief resident in medicine at Albany Medical Center.

Physician, Sketch Thyself

*A psychiatrist asserts that doctors
have trouble writing about their illnesses—
and for good reason*

by James Groves

Owing to the location of my office (close to a general hospital), perhaps to my notorious paper on doctoring ("Taking Care of the Hateful Patient"), and probably also to the nature of the referral network, about one third of my psychiatry patients are physicians. If doctors' family members are counted, the fraction exceeds one half. While this fact does not exactly make me an expert on doctors as patients, it does provide a window on the phenomenon.

Among my patients are also a number of writers, four of whom are writing books. One is a published novelist who may turn out to be one of the great artists of the century. This daily contact with writers and doctors has stoked a longstanding interest in the doctor-patient relationship and led me to study doctors writing about their experiences as patients. Who could better understand patienthood than professionals schooled in medicine and skilled in observation and examination?

Over the last four years, I've col-

lected upwards of 50 articles and a dozen books by doctors on their illnesses, accidents, and medical care. I plunged into this literature sure the collection would reveal a hitherto undiscovered truth about the nature of the self as it enters the world of sickness.

It did not.

I stalled, not because the accounts made me uncomfortable, as they occasionally did, and not because they moved me too much. It was that, with few exceptions (notably Inglefinger's "Arrogance"), doctors writing as patients had less to say about disease, illness, and patienthood than artists writing about even trivial illnesses.

Worse, there was a regression to the tireddest clichés. I recall the moment I threw down the project. It was when Oliver Sacks—ordinarily an excellent writer—writes in *A Leg to Stand On*, just before the accident, "I felt strong as a bull." Really! Even if he felt it, must he say it? And would he later be "weak as a kitten?" I was not going to find out.

Contrast Solzhenitsyn's *Cancer Ward*. Or Virginia Woolf's "On Being Ill":

[H]ow astonishing when the lights of health go down, the undiscovered countries that are then disclosed, what wastes and deserts of the soul a slight attack of influenza brings to view . . . how we go down into the pit of death and feel the waters of annihilation close above our heads. . . . It is only the recumbent who know what, after all, nature is at no pains to conceal—that she in the end will conquer; heat will leave the world; stiff with frost we shall cease to drag ourselves about the fields; ice will lie thick upon factory and engine; the sun will go out.

No physician writing about illness comes close.

Now, at this point someone is thinking, "But William Carlos Williams?" and I reply that Williams' muse was not disease, and not his own. Like other artists who are doctors or medical students (Keats, Chekhov, Maugham, Stein), Williams' main interest is humanity in general. All were physicians or near to it, but none were interested in illness as a subject.

Generally, when we doctors write about our own ailments, we commit two main errors: We underestimate the difficulty of autobiography, and we write in the wrong genre. Northrop Frye's essay "A Theory of Myths" provides a useful point of departure to explore the second error.

Myth has two opposing meanings. The first is a fictional or false belief, the second a transcendent narrative that encodes an elusive fact of human existence and organizes it into a form the mind can grasp. Myths arrange, condense, and codify types of actors in the human drama; they display various possible plot lines in a human life. The two forms of myth relevant here are romance and trag-

edy. Doctors writing about themselves as patients tend to use the conventions of romance when tragedy is the appropriate genre. (Again, Inglefinger is an exception.)

For Frye, romance is the myth of glorious summer, the quintessential wish-fulfilment dream. A hero, born amidst circumstances both prophetic and magical, acquires magical tools (such as helmet and sword) and skills taught by a magician-preceptor. He (or sometimes she—Scarlett O'Hara, for example) is thus prepared to confront the antagonist, an evil figure in the way of the object of the quest (the Grail, ring, immortality, Tara). The hero defeats the antagonist,

fall. Ignoring prophecy, the tragic hero defies the gods and is crushed—but not before the tragic recognition scene in which he realizes that he caused

When a physician is ill or injured and goes on to write about it, a feature of patienthood that almost always leaps out of such accounts is *surprise*. "I thought it couldn't happen to me," or, "I didn't believe what was happening," are characteristic reactions. Of course, denial and emotional numbness are features of the grieving process when any healthy person gets bad news.

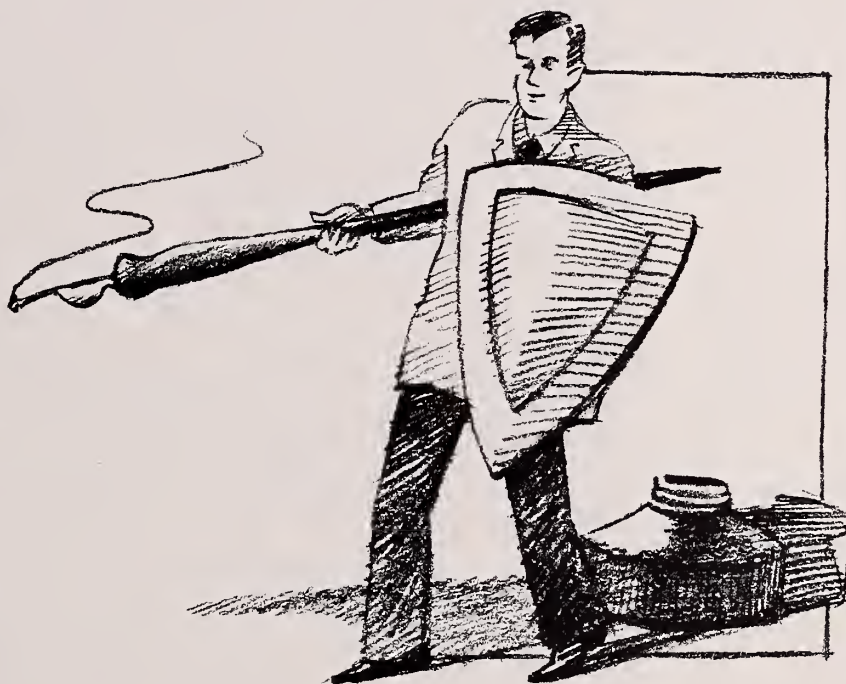
But when doctors get bad news about their own health, there is an extra quality of betrayal superimposed on normal disbelief—a replica of the tragic hero's anger in the recognition scene: "I bargained with the gods, but they have broken their promise."

It is this quality of blame that makes the doctor-as-patient particularly tragic. Inglefinger points out that, as doctors, we tend to blame the patient. Doctors-as-patients first blame fate and then themselves for being sick. Blame turned against the self is shame; turned against the environment, it is judgmental.

Whether doctors-turned-patients are more prone than others to experience shame or self-righteousness as a defense against shame, I cannot say. But my impression from first-person accounts is that we physicians style ourselves as romantic protagonists

in a quest for health and against the antagonist disease—until we are stricken. Our flaw is the belief that it can't happen to us, a defensive denial of our own vulnerability to that ultimate antagonist, death. (Remember: "[T]he sun will go out.")

Another impression I have,



To function well as doctors, we may need a myth of invulnerability. As patients, however, we fall prey to profound feelings of betrayal.

achieves the aim of the quest—and along with it the princess or whatever—and lives happily ever after.

Frye's tragic myth is set in autumn. The hero, first seen in the flower of his destiny (or sometimes hers, such as that of Lady Macbeth), possesses a fatal flaw which leads to his down-

gleaned from listening to physicians talk, is that doctors typically have had, usually in childhood, intimate experience with disease in the self or member. There seems to be a greater than chance association between a certain type of childhood fear of death and disease and the choice of medicine as an adult vocation. I cannot prove it, but I feel that many or most physicians choose medicine at least in part as a defense against these early fears. We create ourselves as romantic heroes—a mythic perception often shared by our patients.

But everyone needs defenses, you might well say, so what is wrong in doctors using undoing (childhood experiences), identification with the aggressor, and denial of vulnerability? Nothing, except that what defenses give when they work, they also take back when they fail. When physicians become patients, the medical romance shatters. Notions of invulnerability desert the doctor and surprise, shame, and despair overwhelm the sick physician.

I offer no solution to this paradox. Doctors may need some myth of invulnerability to function well as doctors. As patients, however, we fall prey to profound feelings of bitterness and betrayal.

At this point readers may feel I am criticizing physicians who write about their illnesses. I am not. Or, if I am, it is defensive. Like most doctors, I have a disease in my past, and, like all doctors, death in the future. And what we forget as doctors, we suddenly recall as patients.

When I fall ill, what will I do to cope? Well, first, I'm sure I'll write about it. For writers even more than for doctors, the vocation is a quest for immortality. □

James Groves is HMS assistant clinical professor of psychiatry, staff psychiatrist at Massachusetts General Hospital, and has a private practice of psychiatry in Boston. He acknowledges the help of John Stoeckle '47, who "spent hours discussing the topic with me and supplied literally dozens of references, providing along with them enthusiasm and inspiration."

But If You Must Write . . .

Groves, a would-be fiction writer, has "collected over the years a number of rejection slips and, with them, some painful but healing advice." He has adapted some of that advice into the following commandments for the medical autobiography.

Be truthful about details. Any telling of an illness or injury that fails to take into account piss and shit, shame, pain, pus and blood—at least as background—is not honest. Any story about being ill that does not at least notice in some ways the secondary gain of being sick—that being observed is erotic and being the center of attention is addictive—is suppressing a fact.

Be tactful. The aforementioned p--- and sh-- are important, but the reader does not need to drown in unpleasantness.

Abandon medical writing. Years of describing medical phenomena spoil the prose style of physicians. We become so used to quantifying that we lose the power to condense and capture the essence. Get a basic text on creative writing and use it. Make exact nouns and muscular verbs do the work; fashion them into sentences of lengths and shapes to fit the idea they carry. Challenge every adjective, and if it cannot account for itself, kill it. Assassinate any adverb ending in -ly. When you find a sentence containing one, restate the sentence, and you'll be amazed at the polish it acquires. Avoid complex verb forms. Avoid the passive voice.

Rewrite, several times. This is the second most important rule (after truthfulness) and the one most often broken. Let an editor see your work. Listen to criticism. Chop out the first and last paragraphs. *There, isn't that better?*

Find your true voice. Start your narrative in the first person, as if it were a letter to an intimate friend. Then rewrite in the third person. Behold suddenly, as by a change in the light, self-consciousness and cowardice revealed. Quick—before you recover—rewrite in the first person.

Take a moral stand. Did your local heroes resuscitate a vegetable? Save a child with 99 percent B.S.A. burns, no eyes and no hands? Perform a heart-lung transplant into someone with Alzheimer's? Complain in print. Someone will call you naive, unscientific, dangerous. But remember: side with civilization.

Don't moralize. If some exhausted caregiver of the above-mentioned burn patient in private refers to it as a "crispy critter," don't judge. Acts matter, attitudes don't. Caregivers' epithets uttered in private are none of anybody else's business.

Postpone. Put your work in a drawer for a month. If it is true, it will still be true when you pull it out. If not, you're better off rereading it in private, not in 10-point type.

Practice. Write regularly, every day, every week, every month. If you do it enough, the zeitgeist will take notice and start speaking the language of the culture through you. Then you stop merely writing and start becoming a writer.

Break all the rules. Except the first one. Writing, like medicine, is one of the holy professions; you cannot protect yourself and still write well. Especially in writing about oneself (and even fiction is autobiographical), there is a subtle tendency to shade the facts and make oneself look better, or at least not so bad. Don't do it. It's like a hairpiece; people can always tell.

Coping With a Quadruple Bypass

*An internist finds that professional
perspective calms fears of
disability and old age*

by James Kreisle

In the chilly pre-dawn darkness of a February morning in 1945, under a thundering artillery barrage, I huddled with my comrades among the vehicles of our mechanized cavalry squadron awaiting the signal to advance across the Roer River into the flaming villages on the opposite shore.

I was 26 years old, and I was scared. Marcus Aurelius's view that in dying we lose only the moment of death—the past having fled and the future having not yet arrived—would not have impressed me in the least. I recall making myself a promise on that occasion that if I survived the war, I would try never to complain too much about whatever else life had to offer.

I did come through unscathed and four years later joined my father in

the practice of internal medicine in my home town—Austin, Texas. For many years afterwards I enjoyed excellent health.

As recently as 15 years ago, my two sons and I made annual December trips to the little mountain ranges of West Texas, places with such romantic names as Sierra Diablo and Sierra Tinaja Pinta. Mornings it was often close to freezing, and the weather ranged from snowstorms to crystal clear.

We climbed the steep and rocky terrain all day, dodging the thorny vegetation and trying always to head into the wind. My legs got tired, but otherwise I did fine. The boys always shot mule deer; I never did, thus avoiding the arduous task of toting the meat down on my back.

In the spring of 1977, my wife

Natalie and I were motivated to shape up for my 35th Harvard Medical School reunion. The object, of course, was to delude my classmates into the belief that we had remained slim and trim since 1942. On Natalie's Weight Watcher program I lost 20 pounds, and she lost nearly as much. Part of my routine was to walk a mile daily before breakfast, which often meant before dawn, running the gauntlet of neighborhood dogs. The first half mile was uphill and the second half down. At first I could do it in 16 minutes with no difficulty.

Sometime in the next two years, I began to notice during the walks a sense of fatigue starting between the shoulder blades and spreading across the upper back. It was not severe and did not interfere with my effort, so at first I assumed it was muscular. Later it struck me that the sensation always began at the same point on my uphill course and that it invariably disappeared shortly after I began the downhill half. I then realized that I had encountered an old acquaintance, and a little experimentation with nitroglycerine confirmed my impression.

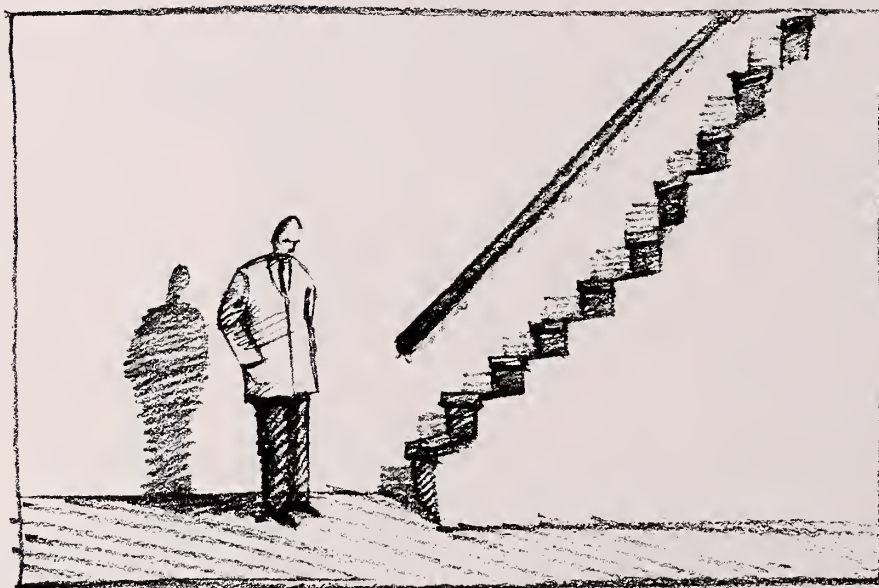
This new threat to my existence was quite different from the artillery barrage of 1945. It is one thing to have a little discomfort in the chest and quite another to hear deafening explosions and to imagine oneself being suddenly blown to bits or horribly mangled and still alive.

Then, too, there is the important matter of the future, so lightly passed over by Marcus Aurelius. Earlier in life, one envisions a long period of interesting and productive work, the launching and growth of a family, and an extended delight in the healthy enjoyment of this gorgeous planet of ours. Later, one has perhaps gone a long way toward the accomplishment of professional and family goals, and experience has revealed that the latter part of life may be unattractive indeed.

It has always seemed to me that a physician, by dint of his or her edu-

cation and professional experience, is in an unusually fortunate position to face with equanimity the physical misfortunes of later life and the inevitable eventual decline in the human condition.

One cannot practice general medicine long without becoming aware that fear, especially fear of the unknown, is among the most devastating symptoms with which one has to deal. Every compassionate physician must spend much time and effort in the control of this most human of emotions. During World War II, Henry Beecher observed that fear is an im-



portant component of clinical pain, and that often sodium amylal gives as much relief as morphine.

By the early summer of 1980, I was unable to keep up for a block with younger colleagues and could not climb a flight of stairs without dorsal back pain spreading down the arms to the elbows. I could see that my disease was closing in on me. My cardiologist, Bill McCarron, conducted a treadmill test, which I flunked badly, as expected.

Not wishing to trust my luck further, I promptly accepted the advice to enter Seton Medical Center in Austin, my hometown, for cardiac catheterization and coronary angiography. From certain quarters there came suggestions that I should rush to Houston, only 175 miles away, where people come from all over the world for cardiovascular surgery.

My gut feeling about the idea was no different from that of many of my

patients. If I was going to be sick, I would feel more comfortable and at ease at home among friends and relatives and in familiar surroundings—and the whole situation would be much easier for my family. Further, I had the conviction that this was not an irrational decision. After all, in my practice coronary bypass surgery was far more common than appendectomy. A dozen or more of my patients, some much older and in worse condition than I, had successfully undergone such operations in Austin and were all still alive and improved. And I had personal knowledge of the skill and integrity of my physicians, all of whom were also my friends.

Finally, it occurred to me that it would be somewhat hypocritical not to accept for myself the same care I had approved for those of my patients who were not intent on going to a better-known medical center. As it turned out, I was the first Austin physician to have heart surgery done locally.

When our four children learned what was impending,

they all unhesitatingly headed for Austin. Nothing could have softened the impact of my ordeal as effectively as their presence and the knowledge of their accomplishments.

At home and with such family support, I had little difficulty in remaining fairly objective in the face of these dramatic preparations. I am sure it helped me to have practiced years before there were any active measures available to contend with coronary heart disease, and often to have watched helplessly while certain patients experienced months and years of intermittent fear and agony. It was great that something could be done.

Cardiac catheterization and angiography were not particularly unpleasant. There were a few needle sticks before cannulation of the femoral artery, and a general warm feeling during the dye injection. Bill McCarron, a former regular Navy submarine line officer, gave me clipped and factual progress reports, as though he were calling out his ship's position

during a dive, all the while pointing out the defects in the dancing fluoroscopic image of my coronary system. The verdict: serious three-vessel coronary disease, including significant narrowing of the left main. Also, blood oxygen values suggested a left-to-right shunt.

I was shocked at the extent of my disease in relation to the mildness of my anginal discomfort. Many a layman would have tolerated this little ache in the back until something more dramatic occurred.

On the following morning Natalie and the kids were in my room early, anxious but not tearful. We kissed all around just before I was whisked off to the operating room where surgeons "Hap" Arnold and Jim Calhoon were prepared to do a quadruple vein bypass procedure. On the way down I was briefly intercepted by surgeon-brother Matt '46, who greeted me and wished me well. Once in the OR, I was anesthetized so promptly that there was little time to contemplate my surroundings.

From what Natalie told me later, the operation must have been much harder on my family than it was on me. I was, of course, oblivious to the vain attempts to locate a left-to-right shunt, the technical difficulty of placing the posterior graft, the problem of getting off the pump, the period of dopamine dependency in the intensive care unit, and the tense family visits that evening.

The family had spent all day in the visitors' waiting room, where my doctors kept them well informed, drawing diagrams for Jim and Margaret, our young doctors. Natalie reported that Margaret seemed to maintain her professional composure until her first view of me unconscious, on a ventilator, and bristling with the tubes leading to support and recording apparatus, at which point she could not restrain her tears. As an emergency room and intensive-care nurse, medical student, and physician-in-training, she had seen many patients in similar straits and worse, but, as she sobbed, "not my own father." At home during the night Natalie was unable to sleep and made several calls to the ICU for reassurance about my condition.

Sometime early the next morning I awoke, aware of the smooth flow of air through a tube in my windpipe, the dripping of blood into one arm, and a dull painful sensation in the front of the chest. My first emotion was that of exhilaration at having

survived the operation. Soon Bill McCarron, who had been with me much of the night, came in and removed the airway. I told him truthfully that I felt all right.

When my family found me up in a chair, hair combed, talking, and confronted with a meager breakfast, they felt there had been a "miracle." By evening I had stood a little and was transferred to the intermediate care floor. Margaret spent the whole first post-ICU night in my room, helping me from time to time and keeping a close watch on my condition.

Quickly I was up walking in the

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halls with less post-operative pain than I had experienced after a herniorrhaphy some years before, and I was back home about a week after surgery enjoying a meal of chili and hot tamales. Soreness in my chest and leg progressively disappeared. Soon I was walking my old route without angina. In five weeks I was back at work, gradually tapering up to full time.

Some friends, patients, and even physicians assumed that after such an impressive operation I must surely be a chronic invalid. Often I had to remind someone that the operation was designed to relieve a disabling condition. For a year I had been studying for my second recertification examination in internal medicine, and I was apprehensive that somehow my

hospital experience might have wiped out many of the details I had been at such labor to remember. However, two months after surgery I took a cardiology course at Massachusetts General Hospital and successfully weathered the examination.

For the next four and one-half years, I practiced full time with the Austin Diagnostic Clinic, supported by an array of medications and an occasional dose of nitroglycerine. What angina I had was extremely rare and quite mild.

Then in late 1984 angina became frequent again, this time front and back, and coming on during the night as well as with effort. With some juggling of medications, things came back under fair control, but I knew that something must have gone wrong inside. In a moment of discouragement, I told Natalie I would be lucky to make it to retirement at age 70, four years in the future.

In early March 1985, there was an abrupt flare of nocturnal angina which forced me to prop up on pillows at night, Natalie inquiring at my least move, "Are you all right?"

In the early morning hours of March 8, I found I could not get sustained relief, even by sitting up in the library and taking repeated doses of nitroglycerine. Of course Natalie was up with me. The pain was not severe, but I envisioned an impending myocardial infarct. Bill McCarron was away, and the cardiologist on call was competent but also young. Like many other patients, and despite the youthful physicians in my own family, I awakened George Lowe, one of our senior cardiologists, even though he was off duty. He could not have been more accommodating.

During a brief angina-free interval, Natalie took me to Seton Hospital Emergency Room. There George was waiting. He found no acute infarct pattern in the electrocardiogram, and soon had me comfortable with a little Dilaudid and a continuous infusion of nitroglycerine. After three days, there was still no evidence of infarction, and I was discharged and comfortable on a whole new combination of medicines.

Upon his return, Bill McCarron rehospitalized me for my second round of cardiac catheterization and coronary angiograms. Two of my four bypasses had occluded. Disease had progressed and produced further obstruction of the coronaries themselves,

and there was a intraventricular septal defect with high pulmonary blood flow and an enlarged right ventricle.

I was thankful, in a way, that my congenital heart lesion had not surfaced earlier in life, thus depriving me of track competition in high school and college and denying me the military service which, having survived intact, I have never had cause to regret.

Angioplasty was not advised. Bill reported our surgeons "enthusiastic" about another operation, a term which hardly described my own feelings, now that I was comfortable again. However, at first I could not walk as much as 100 yards on level ground without resort to nitroglycerine, and during a minor respiratory infection I had a bout of atrial flutter.

The younger members of my family were uneasy about my resistance to surgery and urged a consultation in Houston, where my case was reviewed by Don Chapman, an old friend of mine who had had some of his training at the Brigham, and Dick Cashion, one of his younger associates. I suspected the younger consultant was included because I was under suspicion of choosing someone I thought would agree with my own feelings. At any rate, by that time I was much improved on medication, and the consultants agreed with the decision not to operate. Since I had gone fully prepared for the opposite verdict, I was much relieved.

As I reflect back upon the events in the spring of 1985, I recall feeling much pessimism, if not outright depression, about my prospects. I found it a strangely comforting thought that, because of our clinic insurance program, I might even be worth more in dollars dead than alive, at least up until the point of retirement. I once mentioned this to Natalie, but she took no satisfaction in the notion, and of course I am glad she didn't. I have since improved considerably, and there has been a proportionate increase in my degree of optimism, even though I realize the situation inside remains pretty messy.

For one with my background in geriatric practice, it is no rationalization to observe that, even aside from the well-known physical and mental infirmities of late life, longevity is often not a blessing. The aged are beset by a whole new range of problems at the very time of life when

their powers to cope with them are waning. Logistical and emotional dilemmas arise from the scattering of descendents, the death or disability of a spouse, and the problem of disposing of a lifetime's accumulation of cherished possessions (the owner half-wishing to hang onto them until the bitter end and also afraid to divide them up among descendents and friends for fear of causing quarrels and resentments).

Then there is the instinct which leads many even well-to-do people to cling to a lonely and almost squalid existence at home rather than move to a strange place or dip into the principal of a large estate. I recall one respected and untidy old banker, inhabiting alone at age 95 a large and deteriorating mansion, who was jubilant over saving a dollar on a prescription, even though he had to travel miles to the cheaper pharmacy. The American thrift reflex can operate in bizarre ways among the elderly, doubtless because of our universal fear of outliving our means, as well as of the pride we take in leaving an impressive estate to our descendents.

Years ago General Douglas MacArthur remarked that one should live every day of his life as though he were going to live 1,000 years. I understand what the general was driving at, but his words should not be taken as good practical advice for the average aging human being.

It has been my good fortune to have had over the past decade a peerless office nurse, Phyllis Hivner, who has presided over my practice during periods of my illness, and who keeps everything running smoothly while I am in the office. My patients all love her. For a year and a half now my practice has been confined to the office, nursing homes, and routine house calls. My younger associates do all of the night, weekend, and hospital work. Most of my patients have readily accepted this arrangement.

Not long ago a feeble and tottering old man sat in the chair beside my desk.

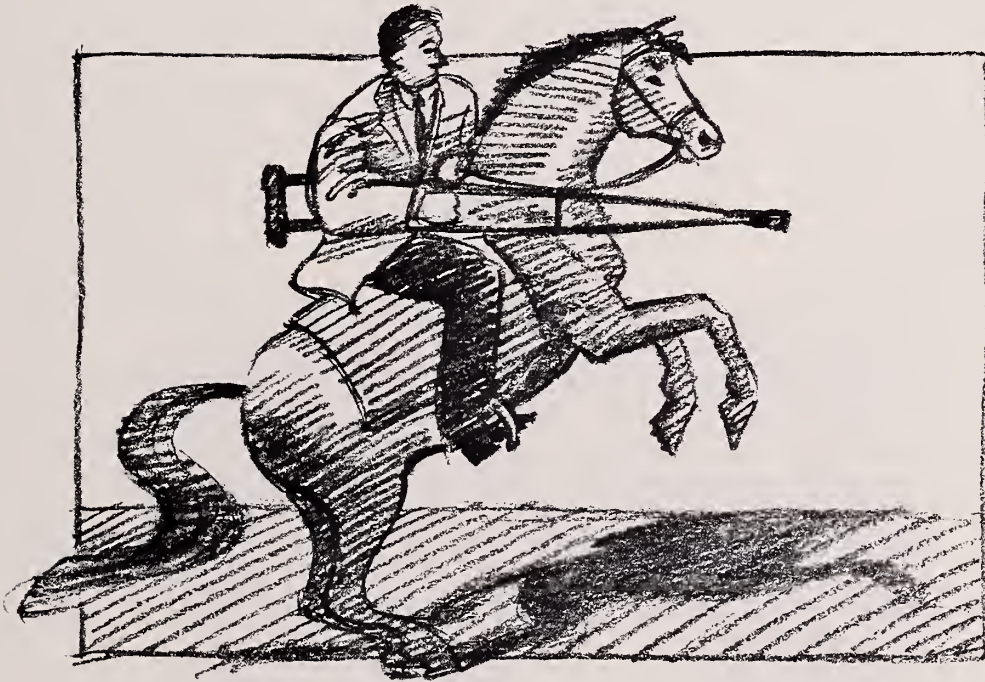
"Mr. Armstead," I asked, "how old are you now?"

"Ninety-five, doctor," he replied, and then exclaimed, "What worries me is whatta we all gonna do when you die!" □

James Kreisle '42 practices general internal medicine with the Austin Diagnostic Clinic.

*It occurred to me that
it would be somewhat
hypocritical not to
accept for myself the
same care I had approved
for my patients.*

Crippled— Who, Me?



Reflections on the healing power of optimism

by Benson Roe

We medical “mechanics” tend to measure our success in terms of physical results. If a mechanical or physiological dysfunction is corrected, we feel satisfied. If not, and if there is nothing more for the scalpel to do, we tend to shrug our shoulders and turn our backs.

But this approach neglects the most important element of disability—the patient’s attitude toward the

impairment and his or her determination to modify expectations and make the most of reality. I first learned about this kind of determination not as a physician, but as a friend and colleague of one who demonstrated it with spectacular facility. Later, when I became a patient myself, his experience helped me.

Arthur Guyton '43A, my most respected and admired classmate, sustained bulbar poliomyelitis while we

were both surgical residents at Massachusetts General Hospital. With a wife, one child, and another child on the way, he found himself acutely ill—on the brink of imprisonment in a Drinker respirator. His physicians doubted he would ever leave the hospital alive.

With very little muscular function, Arthur had to be classified, by any standard, as “totally” disabled. Nevertheless, he stubbornly refused to be deterred from his course. Patiently and doggedly, he developed his few remaining wisps of functioning muscles, adapting them to activities no one would then have thought possible.

Eventually he regained a remarkably “normal” life with sufficient independence to manage an active schedule with no assistance. Without allowing anyone to help him, he takes care of himself, travels, and lectures throughout the world.

As renowned physiologist, chairman of an academic department, prolific writer and researcher, master mechanic and builder, author of the most widely read physiology text in the world, and father of seven Harvard Medical School graduates (several distinguished in their own right), Arthur has clearly accomplished more than several of his normal and healthy classmates put together. He has done so in spite of his need for braces and crutches and his inability to raise his arms even to eat. (He manages by lifting his right forearm with the left hand by flexing his left elbow.)

Because we are all destined to endure the vicissitudes of some physical impairment, it may behoove us to heed his example. Each of our impairments will have a different place in the spectrum of severity. Of greater importance than the severity, though, is the difference in how we perceive those impairments.

Thirty-five years ago, having just completed my residency, I went to Edinburgh, Scotland, on the Moseley Travelling Fellowship with my wife and two small children. I was destitute financially, but was on the threshold of a promising career in surgery. Then disaster struck!

A routine chest film revealed a lesion and a positive sputum ensued. Antibiotic therapy for tuberculosis was then in its infancy and the specter of a severely curtailed life hung heavily across my path. I was sentenced to bed rest. The initial psychological impact was devastating. However, the

physical and emotional support of my devoted wife and the cheerful countenances of my two small children provided strong motivation for me to recover and get on with life. And, of course, I thought about Arthur.

Three months later I was parolled to part-time activity. With consummate disobedience, I traveled across the country, hung out my shingle, forgot my disease, and launched into a strenuous, competitive world. I was lucky to be spared a recurrence. Refusing to acknowledge my disability and its potentially disastrous consequence was imprudent. I knew, however, that

*Some degree of disability
is universal. As we grow
older, the list of
activities that become
uncomfortable or
impossible expands
insidiously.*

a strong and determined attitude might lead to a better outcome than yielding to conventional treatment. In my case it was a matter of refusing to sacrifice the momentum from a career in competitive collegiate athletics and conscientious academic pursuit. Better to lose fighting than to accept defeat.

Thus, I was prepared to deal with another setback when I sustained a crippling pain in my right shoulder about five years ago. A rotator cuff tear was diagnosed and surgical correction was discouraged because it required prolonged immobilization and offered doubtful benefit in my degenerating stage of life. I was told to give up tennis.

Instead, at age 63, I decided to call on the right side of my cerebrum to perform what it had never done. Developing new motor precision and hand-to-eye coordination was an interesting challenge. Achieving reasonable left-hand proficiency, particularly in the serve, was a slow and frustrating process. Persistence and the support of a patient but uncompromising tennis pro ultimately had its reward. I continue to enjoy this recreation on a regular basis, and, despite my advancing years, vigorous sporting activ-

ity remains an important part of my life.

About five years ago, I also noticed a slight drop in my left heel while running in place. Neurologic examination led to the diagnosis of Charcot-Marie-Tooth Syndrome, a progressive motor neuropathy for which there is no known therapy. This process has now advanced to produce a pronounced limp, almost total loss of left gastrocnemius function, and diffuse partial motor loss. Though my performance may leave much to be desired, this impairment has not diminished my enthusiasm for playing tennis, swimming in the ocean, and trudging through the marsh to hunt ducks.

Disability is relative. Some degree of it is universal, and it tends to progress with age. All of us have felt incapable, even in our youth, of doing some of what we wanted, or thought we should be able, to do. As we grow older the list of such activities that become uncomfortable or impossible expands insidiously. More dramatic episodes—myocardial infarction, stroke, cancer, or injury—are likely to increase disability by a quantum leap.

What is not universal, however, is the spirit, determination, and optimism to keep those disabilities from destroying life's pleasures and satisfactions. Stimulating a patient to have this determination is a more important responsibility and an even bigger challenge than mastering the techniques of correcting the pathology. There is no simple formula for imparting this attitude to others.

For starters, we could take more heed of the role the mind plays in sickness and disability. As physicians, we have as much obligation to provide our patients with an optimal chance for psychological as for mechanical recovery. They deserve our best efforts to understand their problem and to encourage a positive approach. A combination of patience, persuasion, and perseverance can be rewarding. Try it; both you and your patients may like it. □

Benson Roe '43A is professor of surgery at UC San Francisco and president of the San Francisco Heart Association. He is formerly president of the Society of Thoracic Surgery, chairman of the Advisory Committee for Thoracic Surgery for the American College of Surgeons, and president of the California Academy of Medicine.

The Care of the Patient

*The man and the patient behind
an epigram*

by J. Gordon Scannell

The patient, of course, was Francis Weld Peabody '07.

No aphorism of Hippocrates is more deeply engraved into Harvard medicine than Peabody's "The secret of the care of the patient is in caring for the patient." That was his concluding thought in a lecture to Harvard medical students and the public in November, 1926.

His father, Reverend Francis Greenwood Peabody, preacher to Harvard, in a memoir of his son, describes the circumstances surrounding the lecture:

Thus the summer of 1926 began at Northeast Harbor with happy anticipation of work and play. In July, however, it seemed to Francis advisable to return to Boston, not for his own sake, but for inspection of summer work at his laboratory; and while there it appeared to him prudent to submit himself to a physical examination while it was convenient both for him and



Francis Weld Peabody

for his medical adviser [Channing Frothingham]. Then, without premonition or anticipation, the blow fell. An exploratory operation discovered the startling truth that his condition was inoperable [John Homans was surgeon]. After a month of convalescence Francis was brought as an invalid to Northeast Harbor, and returned a month later to Boston, not with broken courage or spiritual depression, but with complete self-mastery and serenity, and began his laboratory and hospital service with undiminished fidelity and continuity. In November, he delivered to the staff and students of the Medical School, in the presence of many friends, a public lecture on "The Care of the Patient"—an unpretentious and non-technical survey of the human aspects of the physician's life, which was in fact a summary of his own experience, and which it had given him tranquil satisfaction to prepare. . . .

To those who listened to the address, the scene was particularly touching; for they knew, as he did, that he spoke from out of

[*Francis Weld Peabody*]
spoke from out of the
shadow of disease . . .
each allusion to the
patient as a person,
rather than as a “case,”
carried an unspoken
and poignant reference.

—Reverend Francis G. Peabody



*Peabody in 1914 on his way to China
as a member of the Rockefeller Foundation Commission*

the shadow of disease, and that each allusion to the patient as a person, rather than as a “case,” carried an unspoken and poignant reference.

In a sense, Francis Peabody is a man trapped behind an epigram. His simple one-liner is so compelling and so universally quoted that we fail to go behind it to inquire what sort of a man Peabody was and what he did that we should be mindful of him. According to the son who bears his name, Peabody was aware that this might happen, in fact was happening, during his lifetime. Half rueful, he often said to his wife that all the really important things he had done would fade. But it was only half in jest for he had a cheerful Puritanism that incorporated humor with a sense of human values.

Peabody's friend and colleague Hans Zinsser wrote in a memorial after Peabody's death in 1927:

. . . realizing the uncertainty of prophecy, we feel quite justified in believing that what Osler, the pathologist, was to the preceding generation, Francis Peabody, the physiologist, would have been to our own. For, far as he had gone, he died in

full flight—growing in strength, the capacities of his heart and mind still unfolding.

Two friends were particularly close to Peabody in that last year: William James, son of the philosopher, and Langdon Warner, sometime curator of Oriental art at the Fogg Art Museum. The three of them, products of the Cambridge and Harvard scene, had grown up close neighbors and went to Browne & Nichols School together. The garden of James' house was the locus of Francis Peabody's Indian Summer.

Warner described the scene in the *Boston Evening Transcript*:

We heard sentence delivered and saw him, neither defiant nor stricken by it, walk on his accustomed way. . . . Few understood or could define it, but an increasingly large number of people found themselves involved. Here was going on the thing that each man knows must come to himself, and yet with a difference. A great healing doctor had refused to be dismayed or even much cast down by a sentence of death. . . .

. . . Brought up in a tradition that made shirking unthinkable and being sensitive to the pleasure and pain of other people, he proposed to see the thing through as handsomely as was humanly possible. This he did. And the result was that we, ashamed of our midnight terrors and our petty fears, found ourselves looking to the dying doctor for guidance toward health of body and soul.

. . . In the summer there was much work to be done and only when the vulture, gnawing at his liver, refused to be ignored was there even temporary pause. The mornings were largely given up to writing on the abstruse subjects which engrossed him. Invariably, one or two doctors were with him talking over their problems. . . . As one came on the group over their papers in the garden, it was plain that these doctors, who seemed to be there for their own ends, were in reality the outposts stationed beside him to see that no harm which American physicians could prevent, came to Francis Peabody.

. . . You came hesitating, perhaps, and wondering how you could stand it. But you smoked, gossiped and reported the news, discussed a marriage, a birth, or a death, told your troubles, took some of the invalid's grapes, and left. There had been no sad-eyed bravery about it, no attempt to ignore the obvious. . . .

And all of this time when our hearts were standing still with the pity of it, his task was gently to show us that there was no need for horror. Above all there was to be no fight. . . . He himself needed no convincing on this point, nor did his companion. Those two together, in the words of a distinguished physician who travelled to see him, did more for the practice of



Peabody with George Minot at North-east Harbor

healing than a whole course in the medical school.

Francis Peabody met his future wife in 1914, on his way to China as a member of a Rockefeller Foundation Commission, aboard the transatlantic steamer. Virginia Chandler's home was in Chicago but her lineage was of Virginia. Their shipboard friendship was so agreeable and conversation by the rail became so absorbing that, as the vessel reached Cherbourg, Francis was nearly left behind by his colleagues.

World War I, and later Red Cross duty in Roumania—where Peabody found himself in the direct line of fire of the Russian Revolution—kept their lives apart for five years. In 1919, Francis pursued Virginia to northern Michigan. Shortly thereafter, they were married by Francis' father at her father's house in Chicago on December 18, 1919, and settled themselves in Boston, with anticipation of Francis' tranquil service at Peter Bent Brigham Hospital.

During that long summer of 1927, it was she who presided over the garden scene. As his father recalled,

And all the time came hosts of others anxious to be near, grateful to be sent on an errand, fearful to disturb for a moment the precious seclusion and leisure of the long summer days when the children dug in the sandpile and their mother read aloud under the trees. That house and walled garden had been all his life a valued place for him, familiar almost as his

father's house and full of such pleasant ghosts of noble and wise people that now he took daily delight in it.

A few years after Francis' death, Virginia Peabody married George Shattuck. As his widow, she lived on into her 90s. She died but a few years ago. Her oldest son, Francis Peabody, speaks of her with great affection. He recalls that she told him of his father's awareness that his "important" scientific contributions might be obscured by an outpouring of his soul. She also remembered that in those last few months, the Reverend Peabody and Francis's older sister Gertrude visited the patient nearly every afternoon from 3:00 to 5:00, the best hours of the day. It was Virginia who saw Francis through the other difficult 22 hours of the 24.

Just as Oliver Wendell Holmes reveals more of himself than of his son in his search after the wounded captain, so we learn a great deal about the Reverend Peabody and a father's grief. He writes:

Coincident with these days of unperturbed companionship, the period of invalidism gave Francis time to reflect with fresh interest on the problems of the religious life. . . . It was an interesting coincidence that in the home, and even in the bedroom, of William James, the same evidences which had illustrated to that master the 'Varieties of Religious Experience' were again examined.

*. . . far as he had gone,
he died in full flight—
growing in strength,
the capacities of his
heart and mind still
unfolding.*

—Hans Zinsser



Virginia Peabody in her Cambridge garden with her two sons and Gertrude Peabody, summer 1927

*... we, ashamed of our
midnight terrors and our
petty fears, found
ourselves looking to
the dying doctor for
guidance toward health
of body and soul.*

—Langdon Warner

No harm that there is an element of Harvard parochialism here.

Peabody himself said it this way: "I have begun to find in my own work that I am continually on the border of religion when I talk to patients." Then, shortly before the end, he came down to earth. "This is not so bad as most people think," he said one day, "It's like leaving behind one an old suit of clothes."

Epigram upon epigram! "The treatment of a disease may be entirely impersonal; the care of the patient must be completely personal." "What is spoken of as a clinical picture is not just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears." Peabody leaves out anger. This was not part of his nature.

There is little reason to challenge Zinsser's assessment of Peabody as a latter-day Osler. As the first director of Harvard Medical School's Thorndike Laboratory at Boston City Hospital, Peabody influenced a generation of Harvard medical students and residents. Peking Union Medical College, where Harvard found Peabody when it brought him back in 1922 to run the Thorndike, has found new life as Capital University Medical College. Peabody's career could easily take a whole essay in itself; a

postscript to this piece supplies references.

Peabody's last letter, finished the day he died, survives in print as "The Soul of the Clinic." Written to his friend Warfield Longcope at Johns Hopkins, it describes the complex administrative and personal duties of the teaching hospital medical chief and his belief in an open-door policy towards his junior staff. "What we want," he concludes, "is less of the system and the law that kills and more of the spirit that gives life."

His friend Langdon Warner writes his epitaph:

Perhaps the best thing that Francis Peabody has done for us, beyond leaving his warm, dear memory, is the same that the heathen Theodoridas wrote down over the grave of an unknown Greek sailor two centuries before Christ:

A shipwrecked sailor buried on this Coast
Bids thee set sail;

Full many a ship, though I was lost,
Weathered the gale.

Postscript

For those who would know more, the key reference is the memoir privately printed at the Riverside Press in Cambridge, 1933, by Francis Greenwood Peabody. It is a remarkable evocation of a rare spirit and contains a complete bibliography of Francis W. Peabody. It is available in Rare Books at Countway Library and presumably in other libraries and private collections.

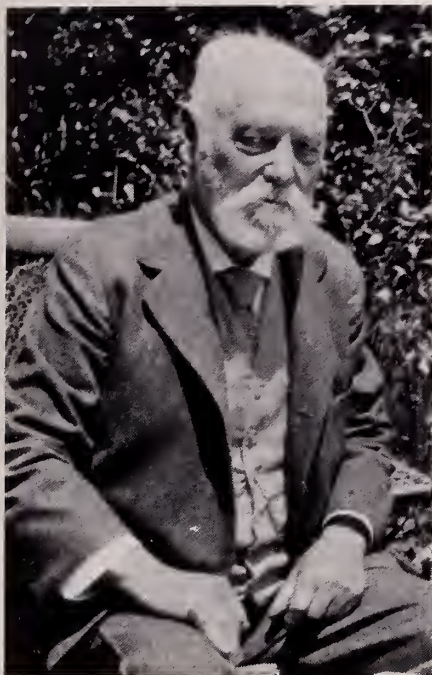
More readily accessible is A. McGehee Harvey's superb essay "Francis Weld Peabody: The Blending of General Internal Medicine and Clinical Science," which appeared in the 1981 summer issue of *The Pharos*. Equally available is "Cabot, Peabody and the Care of the Patient," by Thomas Franklin Williams '50. A William Osler Medal Essay derived from a presentation before the Boylston Medical Society in 1950, it appeared in the *Bulletin of the History of Medicine* (vol. 24, 1950; 462-481).

Hans Zinsser's moving tribute appeared in the *Harvard Graduates Magazine*, December 1927. Langdon Warner's tribute, available in Countway Library, has been privately reprinted from the *Boston Evening Transcript*, November 1927.

Only William B. Castle '21—Bill Castle to all HMS alumni—survives among Peabody's close professional



Peabody in the garden with his wife and sister, Gertrude, summer 1927



The Reverend Francis Greenwood Peabody, summer 1927

sought out in preparing this piece: Max Finland '26, now retired, recalls Peabody only briefly as a visiting physician at Boston City Hospital in March, 1927. Joe Wearn '17, probably Peabody's closest associate at the Thorndike, died last year (the Fall 1985 *Bulletin*). It was my good fortune to spend a delightful hour with him a year ago June hearing about his friend Francis. Oliver Cope '28 recalls that, as a third-year student, he heard Peabody give his famous lecture.

Peabody's oldest son, Francis, lives in Brookline and Northeast Harbor. He has been most helpful, particularly in his recollections of his mother, Virginia Peabody Shattuck. He made available family snapshots which discreetly allow us to invade family privacy. Francis was only three years old when his father died. A brother, Grigsby, was two years younger.

Finally, to anyone who embarks on a Harvard medical biography, the aid and advice of Richard Wolfe at the Countway are indispensable. □

Gordon Scannell '40 is editor of the Bulletin and clinical professor of surgery emeritus at Massachusetts General Hospital.

colleagues at the Thorndike. He has kindly reviewed this manuscript and made the careful constructive editorial suggestion that any writer appreciates. Among others the author

Highlights of Peabody's Career

Intern, Massachusetts General Hospital, 1907-08.
 Assistant resident physician, Johns Hopkins Hospital, 1908-09.
 Fellow in pathology, Johns Hopkins Hospital, 1909-10.
 Student of chemistry, University of Berlin, 1910.
 Assistant resident physician, Hospital of the Rockefeller Institute, 1911-12.
 Assistant of the Rockefeller Institute, 1911-12.
 Resident physician, Peter Bent Brigham Hospital, 1913-1915.
 Member, Red Cross Commission to Roumania, 1917.
 Assistant professor of medicine, Harvard Medical School, 1915-20.
 Physician, Peter Bent Brigham Hospital, 1915-21.

Consulting physician, Collis Huntington Memorial Hospital, 1915-21.
 Associate professor of medicine, HMS, 1920-21.
 Professor of medicine, HMS, 1921-1927.
 Member, China Medical Board of the Rockefeller Foundation, and visiting professor of medicine, Peking Union Medical College, 1921-22.
 Visiting physician, Boston City Hospital, 1922-1927.
 Director, Thorndike Memorial Laboratory, 1922-1927.
 Consulting physician, Peter Bent Brigham Hospital, 1922-1927.
 Member, Board of Scientific Directors of the Rockefeller Institute, 1926-1927.

Student Update

In the Spring 1986 issue, the Bulletin initiated a series of progress reports on the status of minority and underrepresented groups at Harvard Medical School. In that issue, Clyde Evans (director of the Office for Academic Careers) reported on minority representation on the HMS faculty.

The following piece, second in the series, reports on minority students at HMS and efforts by the school to attract and retain them. This report was jointly written by Brenda D. Lee-Walker, assistant to the dean for recruitment and retention; Alvin Poussaint, associate dean for student affairs and associate professor of psychiatry; and the Bulletin staff.

As we go to press, HMS has announced a gift of \$144,000 from the Gustavus and Louise Pfeiffer Research Foundation "to prepare minority students for careers in academic medicine through research." The gift will strengthen the Prematriculation Summer Research Program detailed below and will support a student biomedical research society established by graduates of the M.D./Ph.D. Program.

Eighteen years ago, the black American enrollment at Harvard Medical School was less than one percent. HMS was not alone in being a white preserve: in 1968, only four percent of all first-year medical students nationwide were from minority groups (2.8 percent were black). Until the early 1970s, most black American doctors were educated at Howard or Meharry medical schools.

Now 17 percent of the HMS student body is made up of minority students—a figure well above the 12 percent nationwide goal set in 1970 by the Association of American Medical Colleges. Harvard was recently rated among the "winners" in a *New Physician* scorecard of first-year minority enrollment at medical schools nationwide; HMS finished 11th out of 127 schools. But the hard-won success of HMS minority enroll-

ment is being tested by a consistent drop in applications from minority students over the past decade.

Medical schools across the country are struggling to maintain minority enrollments in the face of declining applications. The nationwide 12 percent goal has never been reached. Minority enrollment of the freshman class nationwide reached an all-time high of 10.4 percent (7.4 percent black) in 1974. This year, reports *The New Physician*, only 8.5 percent of first-year students nationwide were from underrepresented minority groups.

The total number of applicants has also been dropping, but not as fast as the minority pool. At HMS, since 1981, there has been a 24 percent decline in the total applicant pool and a 48 percent decline in the number of minority applicants.

As reasons for the decline in minority applications, educators have cited differences in education preparation among different groups, a lack of strong recruiting efforts, high tuitions, and the difficult financial aid climate. Although HMS's affirmative action program is one of the most successful in the country, HMS applicants struggle with the same conditions affecting the nationwide pool, and the school is aggressively working to maintain and expand its minority population.

Approximately 30 percent of the minority applicants and 23 percent of the non-minority applicants offered admission to Harvard over the last five years have declined the offer. More than 90 percent of the minority candidates who turned down HMS did so for financial reasons; they elected to attend institutions with lower costs or that offered more attractive scholarships and/or low interest loans.

The social climate of the '60s sparked the first nationwide efforts to bring minority students into medical schools. After the 1968 assassination of Martin Luther King Jr., close to 300 HMS students signed a petition urging the school to comprehensively review its ability to train black physicians, and to assess its relation to the black community in Boston. That same year, HMS dean Robert H. Ebert created the Committee for Disadvantaged Students, charging it with increasing the number of disadvantaged students at HMS and Harvard School of Dental Medi-

cine. The new committee recommended to the faculty that 15 slots be created for disadvantaged students.

In 1969, the school began an active affirmative action recruiting program. Though it initially focused on increasing black representation, it soon broadened its efforts to include applicants from other underrepresented groups (Puerto Ricans, Mexican Americans, and native Americans). The school officially committed itself to admitting a diverse student body with a significant percentage of students from underrepresented groups.

One of the initial problems in attracting minority applicants was the relatively small number of applicants from which to draw. In 1969, HMS implemented its Pre-Matriculation Summer Program for minority students. Participants are exposed to the major basic science courses offered during the first year. This eight-week bridge between college and medical school was designed to ease the transition of minority students into HMS and to enhance the likelihood of their academic success.

Despite the decreasing number of minority candidates, Harvard continues to attract a highly talented group. Their career interests range from clinical medicine to academic, public health, and public policy posts.

In recent years, a growing number of HMS minority students have completed the requirements for joint degrees. Of the 114 minority students currently enrolled, six are pursuing joint M.D./Ph.D. degrees, three are completing requirements for the Master of Public Policy Program at the Kennedy School, and two are pursuing M.P.H. degrees.

One of the first challenges facing those who wished to increase HMS's minority population was convincing prospective candidates that their applications would receive serious consideration.

Minority students already enrolled at HMS and Harvard School of Dental Medicine were recruited to help meet this challenge. They currently visit 50 to 60 undergraduate institutions each year to share information and relate first-hand experiences. They also meet with interviewees at HMS, conduct tours, and address questions from prospective candidates over lunch. Newly accepted students often comment that the interactions they had with students already enrolled

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solidified their decision to attend HMS.

Older minority students have also helped ease the assimilation of new students by serving as peer advisers. While social, cultural, and recreational events help bring upperclassmen and new students together, the older students also provide a support network that plans review sessions and shares tips on preparing for the major clinical rotations and the National Residency Match. Students also serve on the Admissions Committee.

HMS has implemented a number of other programs and services to support the admission and retention of underrepresented candidates. Under Alvin F. Poussaint (currently associate dean for Student Affairs and associate professor of psychiatry), an Office of Recruitment and Retention was established in 1975. It is now administered by Brenda D. Lee-Walker. The office remains responsible for attracting underrepresented applicants (including disadvantaged whites) and providing supportive services to all students.

In 1983, the office broadened the scope of the Pre-Matriculation Summer Program. Now known as the Minority Faculty Development Program, this effort provides underrepresented acceptees the chance to do full-time research in the laboratories of medi-

cal-area faculty the summer preceding their matriculation. Students in this program attend a series of seminars on current research issues given largely by minority faculty, fellows, and M.D./Ph.D. candidates. These seminars allow minority students to interact with minority scientists, have meaningful contact with role models, and generally gain a keener understanding of the application of basic science to clinical medicine.

Program participants in recent years have commented that the seminars and speakers significantly motivated their interest in academic medicine. One student's summer project may carry him through his Ph.D.

Related to the Minority Faculty Development Program is the Minority Biomedical Science Society, formed in 1984 to provide opportunities for interaction between minority investigators and students doing research. Students from the graduate and undergraduate schools meet with medical-area faculty, fellows, and house officers at society activities throughout the year.

Since 1982, the Third World Caucus has held the "Third World Weekend" to expose minority acceptees further to the HMS community and resources. Minority acceptees from HMS and HSDM are invited to spend a weekend in Boston interacting with Harvard medical students, faculty, and staff. They stay in Vanderbilt Hall, attend classes, and receive a thorough overview of the HMS financial aid programs and academic resources. The weekend helps minority acceptees make informed decisions about matriculating at HMS, and, overall, has encouraged many to do so.

Twenty-five percent (37 of 149) of HMS minority graduates over the last five years have trained in Harvard-affiliated residency programs. Forty-three percent of minority graduates from 1975 to 1985 have trained in internal medicine. Approximately 10 percent have pursued academic careers. Among the minority graduates of HMS are an assistant dean at Tufts University School of Medicine (Marilyn P. Griffin '77), the commissioner of Health for Indiana (Woodrow A. Myers Jr. '77), and the special assistant to the commissioner of Public Health for the state of South Carolina (Walter Clair '81). The past president of the Association of American Indian Physicians (the late Adoniram (Don) Van Bowen '76), was the first HMS native American graduate. □



The Travel Program Of Alumni Flights Abroad



This is a private travel program especially planned for the alumni of Harvard, Yale, Princeton and certain other distinguished universities. Designed for the educated and intelligent traveler, it is specifically planned for the person who might normally prefer to travel independently, visiting distant lands and regions where it is advantageous to travel as a group. The itineraries follow a carefully planned pace which offers a more comprehensive and rewarding manner of travel, and the programs include great civilizations, beautiful scenery and important sights in diverse and interesting portions of the world:

TREASURES OF ANTIQUITY: The treasures of classical antiquity in Greece and Asia Minor and the Aegean Isles, from the actual ruins of Troy and the capital of the Hittites at Hattusas to the great city-states such as Athens and Sparta and to cities conquered by Alexander the Great (16 to 38 days). **VALLEY OF THE NILE:** An unusually careful survey of ancient Egypt that unfolds the art, the history and the achievements of one of the most remarkable civilizations the world has ever known (19 days). **MEDITERRANEAN ODYSSEY:** The sites of antiquity in the western Mediterranean, from Carthage and the Roman cities of North Africa to the surprising ancient Greek ruins on the island of Sicily, together with the island of Malta (23 days).

EXPEDITION TO NEW GUINEA: The primitive stone-age culture of Papua-New Guinea, from the spectacular Highlands to the tribes of the Sepik River and the Karawari, as well as the Baining tribes on the island of New Britain (22 days). The **SOUTH PACIFIC:** a magnificent journey through the "down under" world of New Zealand and Australia, including the Southern Alps, the New Zealand Fiords, Tasmania, the Great Barrier Reef, the Australian Outback, and a host of other sights. 28 days, plus optional visits to South Seas islands such as Fiji and Tahiti.

INDIA, CENTRAL ASIA AND THE HIMALAYAS: The romantic world of the Moghul Empire and a far-reaching group of sights, ranging from the Khyber Pass and the Taj Mahal to lavish forts and palaces and the snow-capped Himalayas of Kashmir and Nepal (26 or 31 days). **SOUTH OF BOMBAY:** The unique and different world of south India and Sri Lanka (Ceylon) that offers ancient civilizations and works of art, palaces and celebrated temples, historic cities, and magnificent beaches and lush tropical lagoons and canals (23 or 31 days).

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Prices range from \$2,225 to \$5,895. Fully descriptive brochures are available, giving the itineraries in complete detail. For further information, please contact:

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Department HMS 30
A.F.A. Plaza 425 Cherry Street
Bedford Hills, NY 10507
TOLL FREE 1-800-AFA-8700
N.Y. State (914) 241-0111